TEENAGE PREGNANCY PREVENTION

IN CALIFORNIA

1995 POLICY ROUNDTABLE SERIES

REPORT ADDENDUM

SPEAKER TRANSCRIPTS AND SELECTED HANDOUTS

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Edited by
M. Anne Powell, M.S.W.

California Family Impact Seminar
California State Library Foundation
Sacramento, California

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The California Family Impact Seminar provides nonpartisan information to government officials and policymakers concerning issues affecting children and families in California. CAFIS is a joint project of the California State Library Foundation and the California Research Bureau in the California State Library. CAFIS is affiliated with the federal Family Impact Seminar in Washington, D.C. and is part of a network of state Family Impact Seminars.

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TABLE OF CONTENTS

INTRODUCTION

In June and July 1995 the California Family Impact Seminar (CAFIS) sponsored the four-part Teenage Pregnancy Prevention Policy Roundtable Series for state policymakers and their staff. The purpose of the Policy Roundtable Series was to: (1) provide these individuals with the opportunity to explore the myriad of issues surrounding teenage pregnancy with policy, program and research experts; and (2) identify policy and program options for further consideration. A total of twenty-five experts in program, policy, and evaluation research presented at the four Policy Roundtables, including 10 state program representatives. This report addendum contains the transcripts of their presentations and referenced handouts.

Policy Roundtable #1, Underlying Developmental, Psycho-Social, and Environmental Factors Associated With Teenage Pregnancy, took place on June 30, 1995. The speakers included:

- Judith Smith Musick, Ph.D., Psycho-Social Factors Present in the Lives of Teenage Mothers
- Mike Males, An Analysis of Maternal/Paternal Age Data
- Andrea Goetz, Youth Education and Support Services, Battered Women's Alternative, The Relationship Between Male Violence and Teen Pregnancy
- Ed Melia, M.D., State Department of Health Services' Adolescent Family Life Program
- Walt Jones, Young Men As Fathers Program, California Youth Authority
- Marilyn Schuyler, State Department of Health Services' Office of Family Planning Education Now And Babies Later (ENABL) and the Information and Education Program
- Jane Boggess, Ph.D., State Department of Health Services' Office of Family Planning Teen Services Program and Teen SMART

Policy Roundtable #2, Teenage Pregnancy Prevention and the Media, took place on July 7, 1995. The speakers included:

- Bronwyn Mayden, M.S.W., Campaign For Our Children
- Katharine Heintz-Knowles, Ph.D., The Depiction of Children and Teens in the Media and the Relationship to Teenage Sexual Behavior and Pregnancy
- Colleen Stevens, M.S.W., California's Tobacco Control Program and its Relevance for Designing a Teen Pregnancy Prevention Media Campaign
- Julie Linderman, M.P.H., Education Now And Babies Later (ENABL) Media Component

Policy Roundtable #3, School- and Community-Based Teenage Pregnancy Prevention Strategies, took place on July 13, 1995. The speakers included:

- Karin Coyle, Ph.D., ETR Associates, Key Elements of a Successful School-Based Teenage Pregnancy Prevention Curriculum
- Charles "Cal" Crutchfield, M.S., Smart Moves Program, Boys and Girls Club of America
- Suzane Henderson, California's Teen Outreach Program

- Vandana Kohli, Ph.D., School-Based Family Life and Sex Education Programs in California
- Gail Maurer, Healthy Kids, Healthy California, California Department of Education
- Janet Wetta, M.P.H., Family Planning and Teenage Services Program, Office of Family Planning, State Department of Health Services
- Arlene Roberton, Substance Abuse Prevention Programs, State Department of Alcohol and Drug Programs

Policy Roundtable #4, Preventing Repeat Pregnancies, took place on July 20, 1995. The speakers included:

- Mary Wagner, Ph.D., SRI, International, Teen Parents As Teachers Program
- Renee Cameto, SRI, International, Young Teen Parents Consortium
- Terry Carrilio, Ph.D., South Bay Home Support Project, Center for Child Protection, San Diego Children's Hospital, Home Visitation Programs for Teenage Parents
- Sharlyn Hansen, Adolescent Family Life Program (AFLP), State Department of Health Services
- Ronda Simpson-Brown, California Education Programs for Pregnant and Parenting Teens
- Jane Boggess, Ph.D., Office of Family Planning, State Department of Health Services
- Marjorie Kelly, State Department of Social Services' Children and Family Services, The Home Visitation Model and Planning Efforts to Reduce Repeat Teenage Pregnancy
- Nancy Remley, State Department of Social Services' Cal-LEARN Program

1995 CAFIS TEENAGE PREGNANCY PREVENTION
POLICY ROUNDTABLE SERIES

Policy Roundtable #1: Underlying Developmental, Psycho-Social, and Environmental Factors Associated With Teenage Pregnancy

FRIDAY, JUNE 30, 1995, 8:45 A.M. - 12:00 NOON
SACRAMENTO, CALIFORNIA

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:05 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:10 - 9:40 A.M. ***PRESENTATION #1***

Judith Musick, Ph.D., developmental psychologist, former Director of Ounce of Prevention in Chicago, IL and author of Young, Poor and Pregnant. Dr. Musick will discuss the psycho-social and environmental factors that are so often present in the lives of teenage mothers and how these factors can lead to teenage pregnancy.

9:40 - 10:00 A.M. ***PRESENTATION #2***

Mr. Mike Males, demographer and Social Ecology doctoral candidate at U.C. Irvine. Mr. Males will review his analysis of maternal/paternal age data.

10:00 - 10:30 A.M. ***PRESENTATION #3***

Andrea Goetz, Program Coordinator, Youth Education and Support Services (YESS!). Ms. Goetz will discuss the relationship between male violence and teen pregnancy.
Ed Melia, pediatrician and former director of California's Adolescent Family Life Program

10:30 - 11:00 A.M. ***STATE DISCUSSANT PRESENTATIONS***

Walt Jones, Community Services Consultant, Office of Prevention & Victims Services, California Youth Authority
Marilyn Schuyler, Education Now and Babies Later (ENABL) and the Information and Education Program, Office of Family Planning, Department of Health Services
Jane Boggess, Teen Services Program and Teen SMART, Department of Health Services

11:00- 11:45 A.M. ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

11:45 - NOON ***WRAP-UP***

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POLICY ROUNDTABLE #1

UNDERLYING DEVELOPMENTAL, PSYCHO-SOCIAL, AND ENVIRONMENTAL FACTORS ASSOCIATED WITH TEENAGE PREGNANCY

Psycho-Social Factors Present in the Lives of Teenage Mothers, Judith Smith Musick, Ph.D.

Dr. Judith Musick is a developmental psychologist, former Director of Ounce of Prevention in Chicago, IL and author of Young, Poor and Pregnant. She will discuss the psycho-social and environmental factors that are so often present in the lives of teenage mothers and how these factors can lead to teenage pregnancy.

There are a series of questions I have been trying to address:

- Why do the teens have babies?
- And why do they drop out of school and limit their occupational possibilities?
- Why do so many repeatedly embroil themselves in chaotic and violent relationships that put them and their children at very serious risk and then keep themselves from becoming and staying self-sufficient, even when they appear to have opportunities to succeed?
- What are the barriers to positive change for young women in terms of school and work and reproductive behavior?
- What are the internal and external factors that facilitate such change?

I was fortunate in 1987 to receive a multi-year grant from the Rockefeller Foundation's equal opportunity division. It enabled me to step back from my role as the Executive Director of Ounce of Prevention to analyze and interpret a large and very diverse body of data collected through surveys, interviews, observations, videotapes, clinical interviews, journals, and diaries of preadolescents and adolescent parents.

The Ounce of Prevention Fund is a public/private partnership in Illinois between the State of Illinois' Department of Children and Family Services, our state child protection and day care agency, and a private foundation headed by a man named Irving Harris. Mr. Harris has been probably the premiere individual funder of programs for children and families in the United States. He started the National Center for Clinical Infant Programs in Washington, D.C., and the Erikson Institute in Chicago. He joined together with our State Director, each committing $400,000 to this public/private partnership. It has made a very big difference in the kind of programming that we have been able to do. We are now funded by state and federal agencies and a variety of foundations and it has grown to be a very large organization -- with about a $13.5 million initiative for the last several years.

We have many programs all over the state of Illinois. There are two types of programs: some are under the rubric of prevention promotion programs for young boys and girls who are not parents. We also have nearly 40 programs throughout Illinois that are community-based, family support oriented comprehensive programs for teenage mothers, their children, and their

families. We serve thousands of adolescent parents per year and have been doing so since 1983. We issue RFPs to communities that meet our criteria and then help them develop these programs. We have done quite extensive research which I would be glad to share. We also have three inner city high school-based adolescent health clinics. We now have Head Start services for about a thousand of the children of our teenaged mothers so that a young mother can enter in one of our programs during pregnancy and stay until their child goes to school. We receive Head Start funding and funding for experimental programs that we are doing on behalf of Head Start, such as Healthy Start, Fresh Start, and others.

Finally, we have the Beethoven Project. It is in the Beethoven Elementary School District, which is located in the Robert Taylor Homes Housing Project, the largest housing project in the United States, (a series of 20-something buildings). It is a very, very high risk setting. This is a comprehensive program that has been operating for about eight or nine years. We have midwives, infant care, and three Head Start programs. And the Chicago Housing Authority has given us two floors in a building where we run a center which is a family support center, that serves all parents of children under age five in that catchment area. The data that I'm going to talk about come from all of these sources.

In addition to the more obvious negative forces impinging on the lives of poor young women, there is a cluster of underlying and interconnected factors that influence the development of these young women. These factors affect their ability to do right for themselves, and later, for their children. These are what I call the hidden dimensions of teenage childbearing, the indirect but powerful determinants of motivation and behavior. Given the existence of these hidden dimensions, much of the current debate on teenage pregnancy and welfare dependency is remarkably naive and shortsighted, both in terms of why these young women are where they are and in terms of what we as a society can provide to help them take more productive pathways.

I am going to focus on the issues of sexual abuse and sexual exploitation since they are rarely brought into discussions about, "what to do about teenage pregnancy and welfare dependency." These issues are now beginning to be raised and discussed, but in a much more sensationalized, not-so-helpful way.

I would like to talk about sexual abuse as a developmental psychologist, and somebody who has spent my career studying adolescent and child development, what some of the effects of this are, and how it affects a lot more than simply sexual behavior. Shocking stories or statistics are what you see, rather than thoughtful questions about the developmental effects of being initiated into sexuality by force or coercion or trickery at age 9, 10, or 11, or of acquiring your sexual and gender identity through sexual victimization directly by repeated exposure to such abuse in the home and environment. Serious study of these issues indicates that there are profound effects, not simply on the girl's sexual behavior per se. It also profoundly affects the psychological energy she has available to tend to the critical tasks of early childhood adolescence, and it profoundly affects the confidence needed to move into the world and gain the education and interpersonal skills needed to succeed in school and later in life.

Sexual abuse thwarts the development of determination as well as competence because it destroys the young woman's belief that she controls her own life and her own destiny. Lacking such a belief one hardly dares to have or to dream of future goals, let alone striving to reach them. In this way, sexual victimization undermines the desire and ability to seek or take advantage of opportunities. As you know, people are always saying these girls don't really take advantage of these opportunities that are there. Sexual abuse has played a very powerful role in those sorts of things as well.

In 1986 after we had been serving young women for a number of years, our directors from all over the state came together, they began to bring up the issues of sexual abuse, because the girls were bringing them up. I'm embarrassed to say we hadn't really built in anything to address this. They were bringing it from our prevention program in the Chicago public schools, called Peer Power. In the curriculum, a director/guidance counselor stated that they began each program by encouraging the young, pre-teenage women to ask any questions. We expected to hear things about contraception, family planning, and sexual behavior, and about their own sexual development. Instead, what they heard, throughout different sites and from the same teens who were already parents, were questions such as: "Do you have to have sex with your uncle and is it okay?" "If he is not your blood relative, is it okay?" "If your mother's boyfriend isn't a relative, is that incest?" These were the questions that kept popping up. Also, we are currently using a teenage parent model called Meld Young Moms (MYM). It is a teenage parent support group and it has a very extensive curriculum. Once the teenage mothers were comfortable, they began to say things like, "I hope nobody messes with my daughter, with my son." The facilitators would then bring them around to why they would have a comment like that when discussing child development issues. Then it began to come out, "this is what happened to me." Since this really was not my field or any of my staff's field, we brought together experts from all over the United States to help us design sexual abuse research and prevention curricula for our programs.

I will now read you the results of the survey. We did the first survey on the prevalence of sexual abuse among teens who become mothers. Of a sample of 445 teenage mothers, approximately 61 percent reported an experience of sexual abuse when they were growing up. Sixty-five percent of that 61 percent reported abuse by multiple perpetrators on multiple occasions. That is, it was an ongoing situation. The mean age of the first forced experience was 11.5. Most abusers were adult males -- fathers, stepfathers, uncles, older brothers, cousins and mothers' boyfriends -- males in caring and protective roles. It should be noted that in our sample, at least 50 percent of the fathers of these women's babies were older men, girls' wishful fantasies. These men are viewed as protectors, but rarely are they so in reality.

In terms of development, at the most obvious level, girls who have been sexually abused are often confused about what is or is not appropriate sexual behavior. Here is a girl saying, quoting from diaries and journals that they kept as part of our program and from responses that they wrote on the test protocol, "Is it all right to have sex if you're with your uncle if he is not your blood relative?" Or, as one girl put it, "I didn't know it was wrong, I thought we were playing and that's just how older people play." They also don't believe they have a right

to their own bodies. Self-care and protection, that is, contraception and family planning, is predicated on the experience of having been protected oneself while growing up. If you are already sexually "experienced" in this way, notions such as abstinence and saving yourself have vastly different connotations. It is hard to save yourself when you already feel destroyed.

Here is what another girl said, "I learned about sex from my dad. I never had a chance for my first time with a boyfriend. Who knows, maybe I would have waited until I got married, but no, I never got to have that chance. I don't even remember the first time. I feel it ruined my life." I am reading you themes that kept coming up in the diaries and journals the girls shared as part of Heart-to-Heart, which is our prevention program that is now being done in a variety of places across the country.

Being socialized into your sexuality through coercion confuses you about what it means to be female. And it can be a deeply corrupting experience, because the girl may participate in it and even enjoy the attention she gets. Most sexual abuse occurs prior to adolescence. During pre-adolescence when you control a girl's body you control her mind. Since forces that affect one aspect of development affect to some degree all aspects of development, sexual exploitation affects much more than sexual behavior. It affects the girl's sense of who she is. Carried into adolescence when the key developmental task is to establish a sense of identity, the key question, as Erik Erikson said of adolescence, is "Who am I." The answer for these young women we see is, "I am someone who exists to please others and meet their needs, regardless of what is good for me." That is a very strong lesson and it goes very deep. Sexual abuse is thus a form of brainwashing. When your first lessons about sex are taught through force or coercion or trickery, what is affected is the development of self-efficacy, and the sense that you control your own life and, that what you do can make a difference.

There is also a high incidence of boys being sexually abused. However, boys tend to externalize their feelings and identify with the aggressor and become perpetrators themselves. Girls are more likely to internalize negative messages about themselves and continue in the victim role. Here is what one girl said, "I think they (girls) just don't give a care because they get sexually abused and they'll go around just jumping into any other guy's bed. After it happens, they feel so cheap and 'fleezy'" (she meant floozy) "and they don't care about life anymore. They think, they (men) are hurting me so why shouldn't I hurt myself. They don't care, why should I care. So they (girls) will go out and ruin their lives more."

One way that expoitive sexual socialization affects later self-sufficiency is therefore by creating a defeatist attitude. Another way is by robbing the girl of the time and energies and opportunities necessary to develop the all-important skills required to escape chronic poverty. The central developmental task of the pre-adolescent years, the years before reaching teenage years, is to acquire the basic skills and knowledge that will allow you to function in the world beyond home and neighborhood, first the world of school, and then the world of society, which includes work. If your experience diverts your energies from this critical task, your sense of industry, efficacy, and pride in self is diminished. The price is high and you may well spend the rest of your life paying it. Here is how one girl ties these issues together. That is,

how she ties sexuality into what you become as a person: “I feel so sick for the way I grew up. There are so many things I’ve been through that I never should have. I always feel like going back to the age of 12 and doing it all over again. I hate the fact of having had sex so young. I’d like to forget that part of my life. Too bad I can’t. I should have stayed in school and went to college and went on to be somebody.”

Such experiences in the years before adolescence shape a girl’s self-image and notions about who she is and what she could do. Without this base of skills in her portfolio to hold her on course, she is ill prepared for the challenges of adolescence itself. This is especially true in communities where there are many risks and few positive alternatives for young people, many people to exploit them, and few people to shield and protect them, where there are few adults who actively guide them forward and many who wish to divert and hold them back.

It is important to emphasize that sexual abuse means that adults are failing children. Here is what another girl said, “I came out of the shower and my eight-year-old brother and dad were looking at dirty books. I wanted to get dressed, but my dad took away my towel and made me look at the books.” The amount of corruption in that statement! What is in this person’s mind with an eight-year-old boy looking at dirty books. The tableau horrifies me. I had so much data like this for Young, Poor and Pregnant that my editor at Yale said to me, “Judith, you are going to have to take out some of them, one of this particular exemplar will do.” And it’s true. This is just an example of the kinds of things that are happening to children.

As you know, the vast majority of these young women grow up without a father. But being fatherless means much more than not having a father. It means being more vulnerable and without a caring man’s admiration and protection of your budding womanhood. A history of coercive sexual experience often leaves these girls extremely vulnerable to the influence of men, willing to do anything to stay on their good side. Risking their own safety and well-being, and later, that of their children as they repeatedly find themselves in situations where they are re-victimized. It is important to recognize that it is not only men who harm those they should be protecting. It is also adult women who turn their back, betraying their daughter’s trust. Such experiences send a powerful message to a still developing girl that her well-being is less important to her mother than having a man, and that females are powerless when it comes to men.

Here’s what two girls said, “Mothers should be real careful about the people they date or plan to get married with and don’t ever choose a man over your own flesh and blood.” “I never met my father, so I don’t know what it is to have a father, but I do know about stepfathers and some of them take advantage of you. They resemble animals that don’t even respect their own family.” Still the young women I know long for the love and approval of their mothers and keep often fruitlessly searching for it. Indeed, having a baby is also a way to honor and win the approval of one’s mother, by doing as she did and not daring to be different than she is.

The point I guess I want to emphasize very strongly is that the way to prevent teenage pregnancy is by having the roots in your own sense of what you could do. That is, these

young women can't choose to be something other than a teenage mother if they don't have the skills to do it -- if you can't read and write and see a variety of things that you might be able to do and, like middle-class kids do, acquire those skills. The years before adolescence are universally - here or in any country around the world - the years that one learns to be a member of society and gather the skills needed for that. If the child's psychological energy is focused on suppressing what is going on with them in the home, they cannot acquire those skills. There is only so much psychological energy. That is only part of what happens. These girls also go to very poor schools that don't help them, with few guidance counselors, and little personal attention. While being inundated by things forced on them, they lack the emotional energy, time, and people to help them overcome these obstacles and move ahead.

An Analysis of Maternal/Paternal Age Data, Mike Males

Mr. Mike Males is a Social Ecology doctoral student at U.C. Irvine. He will review his analysis of maternal/paternal age data.

I'd like to say at the outset that one of Dr. Musick's original works, The Prevalence of Coercive Sexual Experience Among Teenage Mothers, which was published in the June 1986 issue of the Journal of Interpersonal Violence, has been a major resource that I have used over the years. I am glad to finally meet her and to have a chance to talk about this issue.

What I am going to talk about is very much an extension of what Dr. Musick has already presented - what happens during the teenage years in terms of pregnancy and birth itself and the age of the men who father children born to teens. (See handouts following Mr. Males' presentation). This is an issue I have been concerned about for a number of years. We looked at data from the California Center for Health Statistics for 1990 through 1993, taken directly from the birth certificates. We examined the data. Statistically, there are a lot of reasons to have confidence in ages on the birth certificates being reported by the mothers. There is no evidence of systematic overestimation of age or underestimation of age.

About three-fourths of the fathers are post-school men when the mother is a school-aged woman. This is also true for half of the junior high girls giving birth, and girls giving birth before the age of 16. First, for senior high mothers, there are some pretty clear age differences when the father is a post-school man as opposed to when he is a peer age male. Of 180,000 births, about 50,000 are fathered by school-aged boys and 139,000 by post-school men. For the senior high mothers, the ones with school-aged fathers are only about six months, about a half a year, different in age. But that is a minority of the births in the state. When the father is a post-school man, that average age gap is almost four years -- 3. 5 to 4 years. That accounts for about three-fourths of the births among senior high girls.

The thing I find much more shocking is that, among junior high mothers, when their partner is a school-aged father, that is, a boy aged 10 to 18, an 18 year old and a 13 year old is not a peer relationship, there is still a two-year age gap, even within the, "peer" realm. When the father is a post-school man, the age gaps rises to between five and six years. This accounts for more than half the births, even among junior high girls. I would like to emphasize these are not all just young men. Every 90 minutes in California, a school-aged girl has a baby fathered by a man over the age of 25.

There are considerable racial differences in these patterns. In Alameda County where most of the births involve young black women, 67 percent of school-aged births involved post-school men. The average age of the father is somewhat younger, but it is still a majority that involve older men.

What is the opposite of Alameda County? In Orange County, about 80 percent of the school-aged births are fathered by post-school men. This is primarily due to the fact that whites and Hispanics dominate the population of Orange County, and these teenagers tend to have

somewhat older male partners than do blacks. This is also true of Asians. There is a racial difference, but not a big one. Over 60 percent of the junior high births in Orange County involve post-school men, which is why the Orange County Junior League has become a major player in the adult/teenage sex issue.

We don't often talk about school-aged fathers. A rather surprising pattern that is about a fourth of all school-aged fathers have post-school partners as well. Not so much among junior high boys, but by the time they reach age 18, almost a third of the school-aged males that are fathering babies father them with post-school adult women. So, it goes the other way, but not nearly so much, and the age gaps in this case are much narrower, only one or two years for men.

Of course birth is not the only consequence that we are concerned about. These are also the pattern for AIDS cases. Heterosexuallly transmitted AIDS cases are becoming an area of major concern because this is one of the fastest growing groups. When talking about the incidence of AIDS increasing rapidly among young women, it is because it is heterosexual transmission. HIV infection from heterosexual sex in childhood will show up as AIDS eight to ten years later during teenage years. About 90 percent of all heterosexually transmitted AIDS cases acquired in childhood are in females. For those acquired during teenage years, about three-fourths are female. For those acquired during adult years, about 64 percent are in females. What this indicates is a great deal of HIV infection occurring among children and young women is not from sex with peer-aged partners, but from sex with older men. We also see a similar pattern with sexually transmitted diseases like gonorrhea and syphilis. In addition, there is information coming from the San Francisco/Berkeley Young Men's Study that a lot of boys with AIDS contracted HIV from sex during childhood or teenage years with older partners.

The Alan Guttmacher Institute's Sex in America study found very similar patterns nationwide of teenage childbearing with adult male partners. This is one dimension of teenage pregnancy that is almost never talked about -- the involvement of older men in teenage childbearing. There is historical precedent for this phenomenon. In fact, this has a long history in the United States as a whole. In 1920, about one-third of all births among teenagers, about a quarter million births, were fathered by men over the age of 25. Fifty-six percent involved fathers aged 20 to 24. Only 9 percent of the births among teenage females in 1920 involved teenage males. The proportion of teenage males increased to about 53 percent by 1970 and has stayed at about that level to the present. The proportion fathered by men over the age of 25 dropped from 34 percent in 1920 to 11 percent in 1970 and has now risen back up to about 15 percent. The proportion fathered by men aged 20 to 24 has stayed pretty steady at about 55 or 60 percent. This is a long standing pattern in the United States. In many ways, adult/teenage childbearing was more common around the beginning of the century than it is today.

Mothers under the age of 18 have received a lot of attention from state legislatures and in Washington, D.C. In California, about 80 percent of the births fathered among mothers under the age of 18 involve adult men. About a third of these involve men over the age of 22. If we

are going to focus on teenage mothers, I think we also have to ask: What about the primarily adult men who are fathering most of their babies?

Teenage and adult behaviors are virtually parallel, especially when you break them down by race or by era. There appears to be no difference between the way teenagers respond to the factors that increase or decrease childbearing and how adults respond to those same factors. In fact, the parallel is uncanny, the correlations are very high. They are the sort of thing you never find in social science research when you are looking at independent behaviors. My conclusion is that teenagers and adult childbearing are not independent behaviors. They are really one and the same behavior where not only is there a great intermixing of partners by age but also a great intermixing of the factors that cause marital and nonmarital childbearing, and they are different for races. It is not the same pattern for blacks as for whites. There is the same pattern for black teenagers and black adults, an entirely different pattern for white teenagers and white adults, and another pattern altogether for Hispanic teenagers and Hispanic adults.

In fact, if you look at the external trends in teenage childbearing, there appear to be only two of any importance that I can discern. The trends over time for teenage childbearing are determined by the trends in adult childbearing or whatever factors determine those trends, and the level of teenage childbearing in any particular location or in any particular era is determined by poverty. With blacks, there is a higher rate of births among teenagers than among adults. For white teens, there is a much lower birth rate. For Hispanics, there are very, very similar rates. The trends also grade entirely along the continuum of poverty.

I believe that we have essentially created a myth here called teenage sex or teenage childbearing when actually we are talking about something that is very complex. Even when it involves peer-aged partners, their behavior still resembles very much that of adults. This has proved to be an intractable problem. I think that it is intractable because out-of-wedlock births occur among adults and teens, and that this is why messages aimed solely at teenagers are not going to have a great deal of effect. We have to answer questions as to what can be done about this before we can go any further.

There are several questions to address: Are we going to view most of these adult/teenage births as exploitative? Are they exploitative on the part of the adult male? Certainly some of them are. But as a general matter, are we going to view them that way? If we view them as exploitative, then it would indicate a rather radical shift in policy. We would keep the same assumption that age really is a big factor, that childhood and adolescence is a time of vulnerability and immaturity and adults should bear some responsibility. Therefore we are going to focus most of our programming against the adult male. We are going to look at things like statutory rape laws and the criminal justice system, the welfare system, and some measure of education. We are going to stop focusing on teenagers and trying to get them to resist the behavior of adults and, instead, focus on adults and their behavior.

If you view these relationships, on the other hand, as primarily peer relationships, between people who are in similar positions and have similar levels of maturity, which I think a lot of

people in the field and certainly a lot of teenagers themselves seem to think, then we have a different, very profound, and complex change in programming that would be implied. It implies that we have been wrong about teenage sex, that in reality age is not such a big deal, that teens and adults are at similar maturity levels, especially the adults around or in various proximity to the teenagers we are talking about. We should focus more on the characteristics of individual relationships and not be obsessed with age to the exclusion of all other factors.

When I talked to a number of women at UC Irvine they remember relationships with older men, three, four, five years older than they were, when they were in high school. Most of them view them as quite positive and don't view them as exploitive. But on the other hand, they are not pregnant and they are attending college, so their views and experiences may be different. So these are very complex kinds of things.

Teenagers are part of the adult sexual world and often at a very young age. If we want to change that, I would suggest that we focus on junior high motherhood as a beginning point and also junior high fatherhood, although that is fairly rare. These are features that are pretty unique to the United States in the industrial world. Most industrial countries do not have high rates of junior high mothers having babies and certainly not junior high boys fathering them.

One of the aspects that struck me as very unrealistic about the way that junior high sexuality is addressed in the state right now is the fact that 92 percent of all junior high births involved a partner who is of senior high age or adult age is ignored. About 50 percent involve post-school adults and about 40 percent involve senior high parents. We have assumed that all junior high sex is just with junior high peers. I do not know how much sex there is, but there certainly are not a lot of births resulting from peer sex among junior high schoolers. Their partners are age 16 -- that would be senior high age -- or older. Of the junior high fathers, a surprising 47 percent of their partners are girls who are senior high age or adult age. With boys, again, the age gaps tend to be much smaller.

For junior high girls, 50 percent of the ones that give birth have a post-school adult male for a partner, 19 and older, age gaps of five and six years. Sex among junior high schoolers is considerably different from the the manner in which it is addressed. I am very puzzled by this. I hope now we will start to incorporate this as a central element of programming. For example, if we are going to have mentor groups (this is a very popular thing down in L.A.) where senior high youths and adults go in and lecture junior high kids not to have sex, we need to rethink who is being lectured.

The prevalence of rape among junior high girls is fairly high. A large majority say their first sexual experience was a rape. For many of them, rape is their only sexual experience. This is what we mean by a "sexually active" junior high girl. And these guys tend to be substantially older, older teenagers and adult men.

I suggest we concentrate on this particular area of junior high childbearing for a couple of reasons. When junior high girls say they were raped, I think they are saying very forcefully to us that they did not want to have sex. We have agreement from the target groups, which is

rare, that they don’t want to be sexually active. We don’t want them to be sexually active. Apparently the only people who do are primarily the older teenage and adult males who are having sex with them. There is a history of sexual abuse involved in this as well. It tends to be kind of a syndrome. I think this is an area that we can deal with much more realistically than the area of senior high childbearing and sexuality which seems to be so completely intermixed with the adult world. I would suggest if we can't do anything about junior high childbearing, which is increasing rapidly and is at a fairly high level in California, I don't know that we can do anything about births among older age groups in the state that we might want to prevent.

The Relationship Between Male Violence and Teen Pregnancy, Andrea Goetz

Andrea Goetz is the Program Coordinator with Youth Education and Support Services (YESS!) in Concord, California. Ms. Goetz will discuss the services provided by her agency to youth, particularly the male partners of pregnant and parenting teenage women. She will also discuss the relationship between male violence and teenage pregnancy.

I want to tell you about my first day at work. I started at Battered Women's Alternative in the YESS program a year and a half ago. My primary role is to go into high schools and middle schools all across Contra Costa county, a very large county, and do very interactive presentations on dating violence, family violence, gender roles, and socialization. When I work with the youth I ask them: What is violence? Why is it not safe for people to leave these relationships? What can we do to help somebody who is getting hurt? What can we do to help ourselves if we are hurting somebody else? We do these classroom presentations for students in the seventh grade up through high school. We do them in mixed gender groups, we don't separate males and females. We also train adults to work with the youths.

The premise of our organization, and the premise of the YESS program is developing youth as leaders of change, so we use youth as often as we can. When I was preparing for today, I had a panel of youths help me write what I am saying to you today. So I would like you to know that I'm representing a whole bunch of very brilliant young people.

The one thing I have learned from the youth is that what I considered to be old stereotypes, the woman is supposed to be like this and the man is supposed to be like that, the messages are still out there. The first day I went in to work, I did my own presentation, did a dating violence presentation, and I had a young woman come up to me after the presentation. Her name was Jill and she was 14 years old. She said, "I'd really like to talk with you." So we found a space and talked. Jill told me, "Well, I have a problem." "I'd love to hear about your problem." "Well, I have a four-month-old baby and my mom kicked me out of the house and I'm living with my grandparents." (A common trend now.) "My boyfriend dumped me when I was eight months pregnant, he was 20. I want you to tell me -- I want to get him back." So we started talking about the pros and cons. It is not my role to tell her what to do. "Can you tell me a little bit about the relationship you had with your partner?" She said, "Yeah, well, he said he loved me. He said he was going to take care of me. He said" -- and the biggest incentive for her was -- "I could move in with him." I later learned from Jill that she comes from a really abusive home. Jill was molested and abused as a child. She has no father figure. This boyfriend represents her getting out of the house. She had had previous sexual experience. This boyfriend said, "Let's not use a condom. I don't like that, you know; Trust me." She had no one else to trust. She doesn't know what trust is, but she trusted him. And he left her. He was currently dating her best friend. She was in a small school with a lot of teenage moms. They are isolated, there are no other youths. Meanwhile she is getting verbally abused, she is getting put down in school, called a bunch of names. What's happening to him? No male accountability. He all of a sudden has a high status because we now know he is a man.

That's what I want to talk to you about. I did a lot of brainstorming with young men, talking about the issues of how does violence and pregnancy tie in. What is going on for these young men, and why is a 22-year-old man interested in a 15-year-old woman? So I talked to a lot of people, talked to a lot of teenage moms, talked to a lot of teachers that work with teenage moms, and I worked with a lot of the men that work in our program.

The thing that I want to get across today in particular is that I really don't see the risk factors. I was asked to look and see what are the similarities between risk factors for abuse and pregnancy, and I see them being the same. It is about power and control issues.

Eighty to ninety percent of the teens that I work with in the classroom presentations report a high incidence of family and community violence. They are impacted by it. One out of three teenagers in our surveys in Contra Costa county tell us that they have experienced some form of abuse in their personal relationships. So when I'm talking about teenage abuse, a lot of times people just look at the physical stuff. There is the physical stuff, but in teenage violence it generally starts out kind of joking, and pushing, which can lead into accidentally hit her on the chin as you walk in the door. Then there is the sexual abuse. Sexual abuse in teenage relationships can be date rape, coercion, being forced to have sex without protection, financial abuse, forcing the woman to keep the child. There are a lot of teenage castaways, a lot of teenagers who are forced into prostitution, forced into drug dealing. This reflects what they are seeing in the community immediately around them, a lack of resources, a lack of positive modeling.

And then there is the emotional abuse. This for teenagers, when we work on this in the classroom, is the most confusing because it is so insidious in our society. In teenage abuse it generally comes out in the form of a backwards compliment, "I like your hair when it looks like that." And then it starts twisting and twisting to, "I don't like your friends. If you leave, I'm going to tell your mom we had sex." It builds and builds to threats. So what happens to young people when they are being emotionally abused is they get stuck. They don't see any options. They lose their options.

The teenage abuse that the youths experience is the same as adults. This is the other point I want to make. Lawmakers and adults really need to recognize that teenage violence is severe, is traumatic, and has the same outcome as adult abuse. There are few ways to get out of a cycle of abuse, that is, leaving the situation. For teens that is near to impossible, especially if she is a teenage mom. She has no car, no money, didn't graduate high school. If she goes home a parent may beat rape her. If she stays with her boyfriend, he will beat or rape her. She has no shelter to go to because she is under 18. She is stuck. So she is going to go with the best option, she is going to go with that man who keeps telling her he loves her even though he is threatening to kill her if she leaves. She doesn't have any options.

With the cycle of violence, teens report the same cycle. There is increased tension. They know the ice is going to break and then the violence erupts. Afterwards the same honeymoon, or hearts and flowers period, as our teenagers call it, I love you, it will never happen again, I still want to take you to the prom.

Keeping in mind that there are so many pressures out there for teenagers. In one high school that I go to, I have been called to the same classroom five times this year because the classroom needs mediation. There is a lot of fighting going on in the classroom. I have been in another class six times this year and there have been six different teachers. They are Xeroxing things out of books because they can't afford textbooks. There are no counselors in the majority of these campuses we go to so we provide interns. There are alot of societal pressures on teens these days. Keep in mind 17 and 18 year olds right now grew up in the AIDS epidemic, they are growing up watching people die. So there is this feeling that they would still like to hold on to that feeling that nothing can happen to them. But yet there is also this hopelessness like, oh well, it is going to anyway. Pull-you-up-by-your-bootstraps theory doesn't work when you don't have boots. If a teenage girl is coming from a neighborhood where the only time she sees males leave is if they are getting shot or being put in jail, the only time she sees a woman get out of an abusive home is by getting pregnant and leaving, then she is going to model that behavior. She doesn't have teachers or counselors. A lot of these teens are raised in a single parent home and their mom has experienced the same cycle.

I think it is very important for people to listen to youth and to recognize that this is going on. Knowing that the cycle is the same and knowing that the types of abuse that teens experience are the same, and especially remembering that teenage abuse ends in death. I say that over and over again because people don't want to think about that.

Going to go back to Jill's story, that 14-year-old that is with the 20-year-old, I spent a lot of time talking with her about the positive reasons for staying with him. The main outcome for Jill is that there were no options. She didn't see any options. On an individual level, I think a lot of women growing up in society today are bombarded and their individual images are being impacted by societal messages about what it is to be a lady. I believed that these were stereotypes that were fading away, but the teenagers put these out to me. What is it to be a lady? Keep your legs crossed, only kiss on the first date. What is the male message on a societal level? Be strong, tough, in control. Don't show any emotions except anger and rage. There are no males out there to model in healthy ways.

I am not saying every male is like this. We have wonderful, wonderful male allies in youth at work in our programs. I'd like to reemphasize that we are about alliance building. So I am not here to say that all men are like this, but what I am saying is this is the message that young men give me about how they think they are supposed to be. I am going to be cool if I have a fast car, if I have a lot of money, if I have a lot of women.

We were talking yesterday about the range of active teenage males and the statistics were something like 60 percent of males of a certain age say they are sexually active and only 42 percent of the women say they are, and we are trying to figure out where that fits in. We don't know if the males are inflating their experiences because it is cooler or if the women are deflating because it is still not really okay. They can't go to their moms and say, "Guess what

I did last night." They still can't do that, especially if they are coming from single parent homes where they are modeling their mother or they are getting abused. There is no option.

On an individual level, these men are getting the message that they've got to be tough and strong and in control. They need to make money, they need to be independent, can't ask for directions, have to know what the woman is doing all the time. Now, he's dropped out of high school, he doesn't have a good model, she never had a father, he's growing up in a violent society. If he can't fulfill all of those expectations, he can still have sex and can do that really well. If he's feeling powerless in this society and what society tells him what to be like, well he's going to try to get power over somebody else. Who in society is weaker? Well, when it comes to abuse and violence, it is the woman. The woman is getting the message that, she is going to take it, she doesn't have anywhere else to go. So societal messages impact youth on an individual level and it is a setup for violence and also a setup for pregnancy. All these things are intertwined.

Institutionally the piece that I hear from the teenage moms at the special schools that I go to is they feel isolated. They feel like there is something wrong with them. Why does the father get to stay in high school with all of the friends and she's put over here on this side of the county that she has to drive 45 minutes to get to? What is going to happen to her self-esteem? It is going to go way down. Blaming the victim continues. It is the same victim blaming we have for female teens that get abused. What is she doing wrong? Why didn't she tell him to put a condom on? It's her responsibility.

Institutionally these men are getting a lot of peer pressure to be men. Where are they getting the messages from. Even if they come from a perfectly wonderful nuclear family, they are getting other messages about what it is to be a man. I asked the youth to give me an example. They are like Arnold Schwarzenegger, all these men. Give me an example of who is not a man. Peewee Herman, and things like that. We have this little rigid box that men are told they are supposed to conform in. If they don't conform in this, then they are going to get called a lot of names, they are going to get put down. What is going to happen? They are going to feel they need to act out over somebody else, get control over someone else, or they hurt themselves with drugs or alcohol. For teenage women, it is a lot of self-mutilation, anorexia, bulimia.

There is a lot of stuff going on. Every day I work with hundreds of teenagers and I do not envy what they are going through. It is tough. When I was in high school, I didn't have to worry about going through metal detectors to get into my high school. I didn't have to worry about crack dealers standing outside my front door. And I didn't have to worry about being 12 years old and having a child. I was working with a 12 year old last week who is eight months pregnant. At that age, I was getting braces. It is a different lifestyle, it is a different environment.

We have been talking a lot about the age of the father, because we are never very sure of how old that father is. A lot of times the young women aren't sure. He's got a car, so he's got to be over 16. Maybe, if he has a license. But then we have these statutory rape laws hanging

over their heads. We have a legal program. However, statutory rape laws are really hard to enforce, but people who call to ask us to enforce the statutory rape laws are the parents. It never fails, I get calls all the time from parents. My 15-year-old daughter is going out with this 19-year-old guy. She won't break up with him. I don't like the way he is treating her. I want the statutory rape law used against him. Well, let's see, the girl is 15 and is being abused at home. The guy is her best way out of this home. What is her option? Well, if she gets pregnant, her mom won't press charges.

So we talk to teenagers who get pregnant so they can stay with their partner when statutory rape charges are filed against him. He is held for only 24 hours if at all. What is going to be the outcome for her? More abuse and possible death. We need to improve the laws, we need to take this teenage violence seriously. We need to make it safe for teenage women to report. It is not safe for women teenage to report statutory rape. Our legal program does criminal law and family law. We can obtain restraining orders, we can file divorces. And I admire the strength of every woman that I see walking in there. We have a whole network of support that walks down to the courts with her and walks her back with bailiffs if we need it, because it is one of the scariest things a woman is ever going to have to do. Scary because he is still there, he can still break that restraining order. He can still kill her and she is working against a system that is blaming her, the same system that is blaming these teenage moms.

We need shelters. We need places for teenagers to go. Reports say that 65 percent of the teenagers that are teenage moms experience some sort of sexual abuse when they were younger. I train them as peer counselors so they can work with other teenagers. Every single teenager in this group told me they were molested or raped as children. Now maybe it is a skewed example, I don't know. There are 20 girls in the group and they all told me they were raped. But did they know it was abuse? We need to model positive nonviolent ways of expressing feelings. We need to model for women to hold onto their power. We also need changes in society not to accept this violence anymore. Get on the media and pull that violence stuff off. Children by the time they are in kindergarten witness over 2,000 violent acts on TV. We become desensitized. Teenagers go in and they see Rambo blow away a bunch of people on the screen and they blink. But if someone on the TV screen kicks a dog, everyone asks how can you do that. But we are immune to the fact that people are getting killed every day. This is the same youth that I mentioned that are watching people die from AIDS. You think that it is going to happen so they might as well have as much fun while they're here, because he's going to get shot like his brother and his father or she's going to get pregnant like her mother and her mother.

We really need to take this violence seriously. We really need to find ways to be allies for youth. In Contra Costa County I am really happy to be involved with the Countywide Youth Commission. The District 4 county supervisor started a youth commission so we have 35 youth from across the county that advise the Board of Supervisors. And they are working on the same issues that the Board of Supervisors is. They are taken seriously. Violence is one of the biggest issues facing teens. It is their number one priority on the Youth Commission, so it is becoming one of the number one priorities of our Board of Supervisors.

Talk to your youth. Get your youth involved. Have youth here in your building and talk to them. Like I said, since I couldn't bring a pool of teens in here to talk to you directly, they helped me create this presentation because we need their voice. We need their voice in policy and we need to accept their brilliance and knowledge. We need to make prevention programs available earlier. When it comes to abuse and violence, we have got to get in there in seventh grade, sixth grade, kindergarten and let them know, if you are getting touched in a way you don't like, hey, that is abuse. I am really saddened by 17 year olds saying, "Oh, wow, no wonder I have been having eating disorders, doing drugs, or running away from home 15 times." I thought it was me. Oh, that was wrong.

We need to take teenagers seriously. We need to pull the blame off of them and look at where these guns they are shooting each other with are coming from, look at who is impregnating these 15-year-old women. They are adults. Let's pull back and stop blaming youth and work with them. They are brilliant and they know what is going on a lot more than we do. I really encourage you to go to the source.

State Department of Health Services' Adolescent Family Life Program, Ed Melia, M.D.

Dr. Ed Melia recently joined the Physicians for A Violence Free Society. Before this, Dr. Melia was with the State Department of Health Services, most recently directing the Adolescent Family Life Program. He is a pediatrician who is an expert in maternal and child health issues, particularly with teenagers.

My name is Ed and I'm a recovering violent man. It's actually not funny. I was inculturated into violence as a child by parents who believed sparing the rod spoiled the child. I was trained to know that a real man took what he wanted. As a youth, the major recreational activities of the 30 or so guys that I went around with was to get into fights and to get laid, and so the combination of violence and sex was a constant factor in my life.

My most recent episode of a big slug of violence was about five years ago when my then fourth-grade son's classmate was brutally murdered in her home along with her mother and father in Land Park, and I take a day at a time. That's a 12-step approach to acknowledgment of the role of physical and sexual violence in all of our lives. Everything I said is true, but I think it is something that each of us males and females have to acknowledge, the violence and the sexual victimization that is a part of our lives.

When I read Anne's paper on this in preparation for this, when I was asked to respond I thought that the job was excellently done but that there was a premise that adolescent sexuality was presupposed as a volitional act. I'm very happy to hear the majority of today's presenters point out that volition infrequently plays a role in initial sexuality amongst adolescents.

Our experience with adolescents in the Department of Health Services' Adolescent Family Life Program (AFLP) as we mentioned, was that more and more reports from the youngsters, from the youth, was that their sexuality was initiated against their will. So we modified a psychosocial evaluation as part of our entrance into the program to work with Dave Fine and Debra Boyer in order to do a better assessment of the physical and sexual violence. The data that has been shown to date in that assessment reflects exactly what has been said by Dr. Musick, Mr. Males and others.

We thought we were doing administrative change. It turned out that what we are doing was research, but are unable at the moment to publish this data because we are going through a review with the Committee for the Protection of Human Subjects. But nonetheless the data is accurate and as such valuable.

There is within AFLP a much more clear association of poverty with teenage pregnancy and out-of-wedlock pregnancy than there is with race. As such I think the initiative of a couple years ago which wedded AFLP with the Cal-LEARN Program so that all pregnant parenting adolescents who were on AFDC would get both rewards and sanctions for staying in school is good. The case management benefits of the Adolescent Family Life Program is a tremendous step in the right direction in dealing with teenage pregnancy and poverty.

As we learn more about violence towards women, we learn that there are antecedents to the large number of women who suffer spousal abuse and those antecedents also are present during adolescence and into a pre-adolescence. I want to mention something that has been talked about a lot, the age difference between teenage women and their partners and the early entry of adolescent women into sex. We must consider the fact that there are decades if not centuries of precedence for younger women and older men to have relationships that are sanctioned by society. Certainly it has been the norm for bliss an older man to marry a younger women, even if there is only a couple of years' difference. That has been something, certainly in the culture that I was brought up in, considered appropriate.

So the fact that most teenagers are having their pregnancies by older men and then you consider that two-thirds of teenage pregnancies occur in 18 and 19 year olds who are past high school age and into society in one way or another, it is absolutely not surprising that those young women should be having liaisons with somewhat older men and therefore most teenagers do have their pregnancies by older men. The issue of younger teenagers having their pregnancies by older men and beyond school age is reflected in our survey in AFLP. It is also reflected pretty much so in the data that is coming out now in which women talk about their earlier sexual experiences, how they got into it, and are stuck in the battering relationships that they are in now. It is an issue of power and control. These young women are being controlled by older men.

Recall that there are developmental challenges that adolescents must go through. Now it is premature of menarche, precocious puberty begins now clinically if a girl goes into puberty before age nine. Young women at the age of 12 have achieved 85 percent of the physical and sexual maturity so that you see youngsters walking around physiologically like all of the women in this room, but mentally, not good at abstracting, and not good at thinking about what the consequences of today's actions are upon tomorrow.

I don't know if many of you who have 12-year-olds or you males recall what you were like when you were 12 years old, but it doesn't require a brain surgeon to figure out why these 12-year-old 85 percent physically and sexually mature young women are not attracted to these wimpy little 12-year-old boys in class. They are attracted to the guys who shave who are 17 or 18 or those men in their homes whom they become intimate with in a trusting relationship and are taken advantage of.

There is an extricable relationship between physical and sexual abuse and teenage pregnancy. The notions that have been propounded sufficiently that volition and pulling yourself up by the bootstraps and just say no are appropriate approaches to the solution of this problem should be dispelled.

The other thing I want to mention about violence is in the warrior society that our young people are in right now, when you go onto the streets in Sacramento and Los Angeles and San Francisco and any other city, in Redding, in Chico, there are warriors out there who get up in the morning knowing there are other warriors on the streets who want to kill them. If what

we want to be able to do is to leave a legacy as human beings, those kids want to leave a legacy of their children before that day is out because they are not sure they are going to get back into the bed they got out of in the morning because of such dangers. The warrior legacy has a significant impact on adolescent pregnancy in the tribes that our young people are forming because of familial and neighborhood dissolution.

The family is the gang or the tribe, and the support is sought from that. It's the older family members, that is, the guys in prison and maybe the older people in the Youth Authority that hand down the tradition of family or whatever other name you want to put on a gang from older to younger. That older to younger tradition is, you are a stud and you are macho by taking advantage of the whores and bitches and sluts and roundheels. If you talk about what makes and how you describe a sexually active youngster, you talk about sexually active girls, every name you can think of is pejorative. If you talk about sexually active males, every name you can think of is laudatory. If you talk about sexually inactive young men they are wimps and nerds. If you talk about sexually inactive young women, they are virgins.

The relationship for status in the community that we are talking about around sexually, almost necessitates -- I don't want to make it a deterministic kind of thing -- men being sexually successful by exploiting women and women being denigrated because they allow themselves to be exploited. So that the data that came out and is already supported in AFLP is that these young women are sequentially monogamous in order to attain some sort of value of themselves while nonetheless having gained some of the status of being cool is certainly borne out.

I will end by saying that Gloria Steinem, when asked why she never married and had children said, "I found that I cannot breed in captivity." And a lot of our adolescents are captive in their homes, captive in their communities, and the only way out is through breeding.

Young Men As Fathers Program, California Youth Authority, Walt Jones

Walt Jones is a Community Services Consultant in the Office of Prevention & Victims Services at the California Youth Authority and Director of their Young Men as Fathers Program.

I'd like to give you some numbers about the Youth Authority. A lot of people know that CYA is the place we send kids who get into trouble. But beyond that, the specifics elude us.

We have 9,800 young men and women locked up in eleven institutions, four camps, and two residential drug treatment programs throughout California. In addition, we have 5,900 on parole supervised by parole officers in 17 offices throughout the state. They are all felons. Many are fathers. The exact figure is hard to pin down, but the best survey information we have seems to confirm that 22 to 23 percent of our young men are fathers.

Of the 9,800 who are locked up, the average age is 19. We can get them as young as, theoretically, eight, but usually, 12, 13 years old. And we can retain jurisdiction until age 25. Ninety-seven percent of our population are males. Don't ask me why, that is just a reality. Forty-four percent are Hispanic. Thirty-two percent African American. Fifteen percent are white. Six percent are Asian. Three percent are other.

As I say, we know that about 23 percent are already fathers. Probably the real figure is higher. There is also another subgroup within our population, men who have a relationship with women who have children by other men. They serve in a father-figure role in these situations. There is also another phenomenon in the Youth Authority. Our young men come from families that are somewhat dysfunctional. Their own parents have often been to prison and are not effective parents. If they happen to be the older brothers in the family, quite often they are father figures to their younger brothers and sisters. So we have a rather large population that serves in a father figure role, and a large percentage are fathers themselves.

We became concerned about these numbers. In fact, they are much larger than what we first estimated. Four or five years ago, we thought maybe 10 percent of our population were fathers. We were concerned then that we needed to do some programming in that area. As we began to survey, we saw these numbers were actually much higher.

We also knew three things about the population of fathers and father figures. One is that there is a very high correlation between child abuse, child maltreatment and later delinquency. If there is an effective means to prevent future delinquency in the children of our young men, it would be by providing programming that would deal with the issues of maltreatment of their own children. So that is one of our premises.

Second, being a good father is an effective means and a positive goal for our young men. If they take their parental responsibility seriously, they start to change their own behaviors and act differently. We believe that they will achieve a much higher success on parole if they adopt that responsible role.

The third and most important premise is that we believe that most children do better with the fathers in their lives, not necessarily living with these children, because there is a whole range of family structures among those homes. But if the fathers are in their lives in a responsible, active way, we believe their children are going to do better.

So those are the premises on which we began to develop the program to try to help the young men become more effective fathers. And why just concentrate on the young men? Number one, we have had parenting programs for our young mothers for some time, but we have not had parenting programs for our young men. And second, there are overwhelming numbers of young men in the Youth Authority population. Ninety-seven percent of our population are men and we have not had parenting programs for them in the past.

So we developed a program and were successful in getting a US Department of Health and Human Services grant in the amount of $150,000 a year for three years to offer this program in four of our institutions. We also got a grant through the State Office of Criminal Justice Planning to do related programming in four of our parole offices.

You can see from the earlier numbers I gave you, our program only touched only a small proportion of our total population. We started it in 4 institutions out of 11, and only 4 parole offices out of 17. But it was a good start. Later, because of some savings that we had of grant money, we were able to expand the program to an additional institutional and to a forestry camp.

There are three elements of our program. First is a 60-hour curriculum classroom instruction on parenting education. Second, special family visiting day activities help reinforce what they learn in the classroom. I'll describe these activities in a little more detail later. Third, we have matched father role models from outside the institution with our young fathers, again, to reinforce what they are learning in the program.

The 60-hour curriculum: Two and a half years ago when we started the program, we looked around the nation and there weren't too many programs that were appropriate for a young male, mostly minority population. We knew if we were going to do a good program, we would have to create a curriculum from scratch. We got information from several sources about how to build a good curriculum. We held a transfer of knowledge workshop about two years ago in Southern California in which we invited parenting experts from throughout the state and the nation to sit down with our staff over a three-day period to tell us what they thought would be effective programming for this population.

In addition, we drew upon the experience of the Youth Authority's program staff. We have 4,300 employees throughout the state, who are experts in youth programming.

One of the most important sources of information is from the program participants themselves about what is effective for them. We traveled throughout the state and formed groups of our young men and asked them what they need in order to become effective fathers. Based on all

of that input and a lot of hard work by a group of Youth Authority staff, we created the 60-hour curriculum that we hoped at the time would be effective for our population. Our subsequent experience showed it is a good, effective curriculum.

As of December 31st, 1994, the most recent information I have available, we've had 510 young men attend the program, through the 60-hour curriculum. And we've held special visiting day activities in all of our institutions. Visiting day in correctional institutions gets to be very difficult because it has to be in a secure setting and there is not a lot of freedom to bring in the young children and the mothers of the children for visiting. We set aside these special days just for the families, for the children, for the mothers, for whoever in the family want to come in, and we also set up special activities that help the young men understand and put into practice what they have learned in the classroom.

Our mentor program is just getting off the ground. Because of the remote locations of our institutions, that's a rather difficult thing to do. But we think it's effective to have good fathers come in and be role models to our young men. It's interesting that we take advantage, in a way, of our captive audience.

The participation in the program is voluntary and we want to limit it to just the young men who are fathers or will be father figures. When they are in the classroom or involved in the program activities even though they are in a captive situation, without exception they express a sincere commitment to being responsible fathers. It has been my experience in visiting the program in our sites that they want to be responsible fathers and they don't have the tools to do it. They bring with them a life that has led them in a different direction and caused them to end up in correctional settings. It also makes for a good classroom situation when you have that degree of commitment. Not surprisingly, we get about 100 percent attendance in our classes every day. Some drop out because they do have to get involved in other activities. But that commitment, we hope, will be a basis for leaving the institution onto parole and becoming responsible fathers.

In terms of evaluation, the immediate evaluation component we have is to simply test what they know and what they do, comparing pre and post program experience. The program is ripe for long-term research. We believe that the young men will do better on parole because of their participation in this program. However, most of the young men who have been through the program in the last two and a half years are still locked up and there are no real experiences to draw on. There won't be for a year or two after they get out on parole.

Then, there is a third element of the evaluation we'd like to add that would collect data on what happens to the children of the young men. We are not going to know the impact on the children of the young men for another 10, 15, 20 years. So while we are evaluating what is happening immediately, we have got an eye down the road to try to track what happens to the children of the young men.

We believe that being locked up doesn't absolve the young men of their responsibilities to be effective fathers. Our population has not typically assumed responsible father roles much less

responsible roles in the community. We think this program will go quite a ways towards achieving that goal.

We were beginning to get concerned about what might happen to the program after the grant funds run out, which will be December 31st, 1995. We were starting to think about what we can do to incorporate the elements of the program into the Youth Authority's budget when a great opportunity came up. The governor held a Fathers Summit a couple of weeks ago in Burbank. We provided some information about our program to the governor's office and provided some panelists to that summit. As a result of our participation in that effort and the governor's response to it, he has issued an executive order which does several things. Among them he is directing the Youth Authority to expand its parenting program to all institutions, camps, residential drug programs and parole offices. No mention of money yet, but we're working on it. We are pleased that a three-year pilot program that typically goes away after the grant funds go away is going to continue because of the interest it has received and, I think, because the program makes sense.

Education Now And Babies Later (ENABL) and the Information and Education Program, Office of Family Planning, State Department of Health Services, Marilyn Schuyler

Marilyn Schuyler is a Health Education Consultant in the Health Education Section of the Office of Family Planning. She will describe two OFP programs: Education Now and Babies Later (ENABL), and the Information and Education (I&E) Program.

The Office of Family Planning has funded Information and Education (I & E) Projects since 1972. I will be talking very briefly about the projects targeting adolescents between the ages of 14 and 18. Many, if not the majority of these adolescents are high risk. I'd like to describe to you the characteristics of these programs as it relates to these adolescents.

Basically, I & E Projects are funded in 18 California counties. There are 33 projects. The criteria for funding these projects includes the number of teenage births in each of these counties, ethnic composition, and the need and risk status of the target population that are being proposed to be served. Thirty-two of our 33 projects statewide target adolescents between the ages of 14 and 18. The goal, of course, is to prevent unintended pregnancies.

The characteristics of programs targeting teens include that these are community based health, education and social services agencies. These agencies have credibility and experience serving the youth population. Another premise is that these agencies are required to actually provide mechanisms for input by the youth they are serving into the planning, implementation and evaluation of programs. This is done through focus groups and also through youth advisory counsels.

Another basic premise of these programs is that there is very strong parent involvement in the education component. The Office of Family Planning has always believed that parents are the primary support of their children. We, in reference to our preteens, young teens, and adolescents, include community parent information sessions which inform parents about the curricula their children are receiving. They also include parent education programs which provide parents with the knowledge and skills they need to be more capable educators for their children.

Another very important part of these programs, and I think it relates to what you were talking about earlier in terms of risks, is a referral network for youth that are at very high risk. All of our education programs are required to participate in the development of a community referral network that addresses those factors that place teens at risk for teenage pregnancy. That includes resources in the community that provide family planning services, STD counseling, services for sexual and physical abuse, services related to school performance and difficulties, family problems and substance abuse. In addition to participation in development of this network of referral services, our projects also provide the youth in their educational programs with information regarding these referral services. They also provide individual referrals to youth.

Another very important aspect of these projects is the community involvement component. We have strongly believed that teenage pregnancy is a community concern. In order to really address the problem effectively really requires community organization. Projects are required to develop and implement a variety of community organization activities. Typically this includes involving business leaders, community leaders, recruiting and training volunteers, and developing and participating in community teenage pregnancy prevention task forces. This is a very, very important focus for our programs.

The next component that they develop and implement is a community awareness component. This is basically local media. We also firmly believe that communities need to be well-informed regarding teenage pregnancy problems in their communities. Our projects implemented radio, TV, PSAs, as well as local newspaper articles and so on and so forth. So community awareness is very important.

Another component is what we call "school-wide activities." Our projects have increasingly become focused on not only addressing individual behavior change. We are really trying to impact on community norms in terms of what is acceptable by way of sexual behavior. Our community organization efforts and our school-wide activities are really focused on attempting to influence norms. We see the school as a community, and so the effort in implementing activities beyond curricula is really trying to impact those norms school-wide. Activities typically include youth conferences, health fairs, rap contests, poster contests, school newspaper articles. Another critical aspect of this is the teens are designing and implementing these activities themselves. We see that as critical to ultimately impacting behavior.

Another aspect is male involvement. OFP has become increasingly concerned with and involved in recognizing the need to address males in teenage pregnancy prevention. Our projects are actually increasingly targeting abusive males, increasing the number of male staff, educators. They are also recruiting male volunteers and involving them in their agency efforts.

Lastly, and I think this is really important from the health education perspective, we have become much more closely aligned and responsive to what research is telling us. I think the information that was shared with us earlier today is of tremendous value. We have actually begun working in reviewing CDC research, which was focused on effective teenage pregnancy and STD and HIV prevention curricula across the country and additionally identifying characteristics of those curricula. Last year we had a major shift in our local projects and placed a very high priority on their utilizing and evaluating the curricula that had been proven to be effective. That is a major shift because traditionally our projects really focused on comprehensive sex and family violence education. The CDC research is really showing a much more focused approach in terms of curricula that is more effective.

The other aspect of this is that we are much more outcome oriented. We are very clear in terms of sexual behavior which includes condom use, and reducing the number of sexual partners. So we are looking at the utilization of curricula that are effective in achieving those

behavioral outcomes. Also local agencies do adapt the curriculum to make them responsive to the needs of the youths that they are serving.

Another very important point that I'll just address briefly is that our I & E Project also has a curriculum development component for high risk youth. We are very excited about this collaborative effort with UC Berkeley, ETR, and a select group of our I & E contractors. What we are actually involved in is developing two curricula for high risk youth that will be implemented in sites serving high risk youth. Criteria for selecting these target groups are: (1) there had to be a significant number of these youths that are currently served by a project; (2) it would impact on teenage pregnancy and STD rates; (3) we would likely be effective in achieving our desired behavioral outcome by targeting these youths; (4) there are effective curricula not currently available for these youths; and (5) given the complexity of the risk factors that we are talking about, how our focused pregnancy prevention curricula can in, coordination with other educational and counseling interventions, effectively address the complexity of these high risk factors.

This is what we feel is a critical challenge for us in terms of education. We really need to coordinate what we are doing with other services and educational programs that are being offered in a variety of settings. The settings that we've actually identified are continuation high schools, juvenile justice, and foster care group homes. The other very important part of this is that these curricula need to be designed so they can be successfully implemented. We can come up with the most fantastic curricula and, unless it can be accepted by these institutional settings and implemented in the sites, our projects will not succeed.

The process that has just been completed is looking at issues of attrition rates, length of stay, gender, structure of the system, group size, flexibility for implementation, number of sessions, length of sessions, site specific needs and restrictions, and scheduling issues. We will be developing these curricula over the next two years, and pilot testing, then they will be utilized by I & E projects.

In terms of ENABL (Education Now and Babies Later), one thing I would like to emphasize is that it was conceived and implemented as a multifaceted comprehensive program targeting teenagers between the ages of 12 and 14. The emphasis is on postponing sexual involvement (PSI).

It includes the PSI curricula, and local community involvement. You will start to see themes over and over again in terms of our health education programs. Parent involvement, school involvement, community agency involvement, and the local media. Also there is a statewide media campaign and a training component as well as a comprehensive process forum for impact evaluation. We do not have the impact report results yet, but hopefully those will be available soon.

In terms of really looking at the issues of risk and how ENABL relates to that, when we funded our 28 local ENABL contractors, priority was given to their serving diverse ethnic groups and their ability to deliver ENABL and PSI successfully to youth in areas of high

teenage birth rates. ENABL contractors disproportionately are located in communities with high teenage birth rates, and the youth they serve are representative of youth in higher risk communities in California.

I'm not going to go into a lot of detail about the PSI curriculum, but one thing I do want to emphasize is it does focus on peer pressure, social pressures, and media pressure to become sexually involved and, very importantly, it is skill based. It helps teens not only identify pressures, but it helps them develop skills in terms of setting limits and teaches assertive responses to resist pressure and also provides practice and reinforcement for young teens to utilize these skills.

We do have some very interesting youth satisfaction data. The reaction to the program has been very positive. Over 5500 satisfaction surveys were administered to youth and 82 percent of the youth rated the program good or excellent, two-third rated the program important for people their age. In general this was reflective of youth from all ethnic groups. Interestingly enough, boys were responsive but less enthusiastic about the program than girls. Youths who already had a serious boyfriend or girlfriend were less satisfied, especially boys.

Very importantly for us in terms of utilizing the information to improve the program, more than 77 percent wanted a longer program and they wanted additional topics addressed. The most mentioned were how to keep from getting STDs and HIV (82 percent); healthy and unhealthy relationships (73 percent); ways to show affection without sex (72 percent); and birth control (60 percent).

Additionally, UC Berkeley and ETR conducted focus groups as part of their formative evaluations. The youth who participated in the focus groups made some very good suggestions in terms of improving the program. They suggested that we offer ENABL before youths experience sexual pressure, depending on the norms of the particular area. I think this relates to the information shared earlier. ENABL basically is primarily implemented in seventh and eighth grades. But in communities where youth are sexually active at younger ages, then flexibility is provided in the program to actually implement it in sixth grade.

Another suggestion was that there be more class sessions. The first reason they gave for more class sessions wasn't the content. It was that they wanted to get to know the leader better. I think that from an educational perspective this is very important, because our education leaders also serve as mentors and role models. Many of these leaders are in a position to develop relationships with youth, to become those mentors and role models.

Teen Services Program and Teen SMART, Office of Family Planning, State Department of Health Services, Jane Boggess, Ph.D.

Dr. Jane Boggess is the Chief of the Office of Family Planning with the State Department of Health Services. Dr. Boggess will describe the Teen Services Program and Teen SMART, the governor's new program to reduce teenage pregnancy.

The Office of Family Planning spends $46 million a year in medical services. Expanded Teen Counseling is a program that was developed in 1991 as a result of Governor Wilson's initiative to enhance the Office of Family Planning and address teenage pregnancy prevention. These are three-year projects, with about 30 contractors, and they serve about 45,000 people a year.

The project is based on the assumption that teens require more in-depth counseling and support intervention. There are about five program components. There is a detailed risk assessment. When the kids come to the clinic for medical services, there is a counseling component. In the original project there was the development of a community resources network for research and follow-up.

What I thought might be interesting is to talk about the profile of our teenage clients. 34,000 teenage clients were surveyed in these programs over a two-year program as part of an evaluation. So this is a snapshot of the teenage clients. These counseling programs are part and parcel of our clinical services. I think one of the things you have to realize is that this population is different in some ways from other populations. They are in the program for a health related reason, either to seek a pregnancy test or contraceptive services, and for adolescents they have already displayed considerable future planning skills. These clinics don't have walk-ins. For the most part they have to make an appointment, schedule it, remember to go to it a week later, get the transportation to get there, and wait for a couple of hours. This is somewhat unusual.

Ten percent of these kids are receiving AFDC. Seven percent are enrolled in WIC. One-third are 14 years or younger when they first initiated sex. Eleven percent said they had been tricked or forced into having sex. Eleven percent also said they already experienced an STD. Twenty-seven percent said they had already had a previous pregnancy. About 20 percent cited one pregnancy and 5 percent cited two or more pregnancies. Now to put that into perspective, the program serves 45,000 teens a year, 12,000 a year who have already experienced pregnancy. Almost all had someone in their family who had been in a similar program and had depression and suicidal ideations. Thirty percent requested assistance in finding a job, which gets back to issues of the tight correlation between risk of teenage pregnancy and poverty.

I think that for most of us sitting here who come from actual government programs we have been kind of successful in addressing high risk populations, but there were some facets in this complete profile that, for me at least, were somewhat surprising. Twenty-one percent of the same youth surveyed said they had already been tested for HIV and AIDS. Two-third said

they had only had one sex partner in the last six months. Sixty-two percent tried to avoid getting pregnant the first time they had sex.

One of the markers that people use in terms of profiling contraceptive behavior is to ask people what happened the last time you had sex. When kids were asked whether they used contraction the last time they had sex, more than half said they had used something. Forty-two percent stated that the reason they were coming for their initial visit was a pregnancy test. They may receive other intervention such as birth control, but pregnancy testing was the reason they identified upfront.

When we asked kids what they would do if they were pregnant, 45 percent said they would continue the pregnancy; 29 percent said they were unsure; 23 percent chose abortion; and 2 percent said they would opt for adoption. To me there are a number of things surprising about that kind of aggregate client profile. Most clients show some familiarity with birth control. Half of them used a method of some sort the last time they had sex. They must be fairly sophisticated in terms of navigating health services. Twenty percent said they used some services such as HIV testing. You look at their patterns of sexual relationships and most of them appear to be in a monogamous relationship. It may be serial monogamy, but they are not having multiple partners over big chunks of time. A large percent suggested they would have the baby if they became pennant. This really ties in with the things we are hearing from other speakers.

Teen pregnancy is a complex issue. I think one of the ways we can most successfully address it in California is shifting the paradigm slightly and see it as a symptom of a problem, as a whole bunch of different problems.

Getting back to what the program did and where we are going to with the program, the evaluation is coming out in July and the program is focused on these responses. Evaluations are never uniformly successful or uniformly a disaster. In this case, there are very strong signs of having an impact. We have had testing control over the control groups from it. It was a really rigorous methodology because it was implemented as a very basic sort of intervention program and researchers tagged onto it. Our control groups consist of clients that go to those clinics in California that didn't receive the special intervention services. There is a big statistical difference and it's a significant difference in terms of the number of teens served at the sites that had this. The Expanded Teen Counseling Program served a lot more teens. The biggest increase in terms of ethnic diversity in relation to population increased by 40 percent overall as a result of outreach efforts in clinics that had the Expanded Teen Counseling Program. Almost half of the noncontraceptive users in the program showed marked improvement in their contraceptive compliance. Kids enrolled in these programs statistically showed greater utilization of more effective methods than had kids who were not enrolled.

One of the things that was a bigger part of the initial program was really trying to link up kids that came into clinics with services on a broader basis in the community. In terms of that component, we weren't particularly successful. The reason is that in California the services weren't out there. If the kid needs mental health counseling or any other services -- these

services are very difficult to access. And it is really a greater task than one program can do in terms of trying locally to develop a network. There really has to be something going on with the local level such as offering contraception talks with a youth council. Some areas have been very successful in terms of providing this. There needs to be a coordinated, top-down bottom-up approach to be able to expand the network. I personally believe in that kind of collaboration to effectively address this problem. It's linking up with other programs and breaking down this fragmentation that we have experienced.

What we will be doing over the next three years is really focus on the counseling component. We have developed a standardized counseling manual that is sort of patterned after CPSP (Comprehensive Prenatal Services Program) in the sense that it provides very standardized structures and counseling protocols, linking up clinical services, and detailed assessment documents. The other thing that we're doing to enhance our program efforts with the Expanded Teen Counseling Program is to do much more targeted mapping for our outreach component locally.

Historically in California and across the country all of your teenage birth data is presented either at the state level or the county level. Counties are extremely diverse in terms of poverty, in terms of ethnicity, in terms cultural factors, and we are about to launch on a project with UC Berkeley's School of Public Health to begin looking at high risk counties in California on a community based level, taking zip code data and aggregate them into communities. We want to get buyoff from communities that in fact these are the areas that are at greatest risk and really use this information to much more effectively target the interventions that we offer in the Office of Family Planning.

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1995 CAFIS TEENAGE PREGNANCY PREVENTION
POLICY ROUNDTABLE SERIES

Policy Roundtable #2: Teenage Pregnancy Prevention Strategies and the Media

FRIDAY, JULY 7, 1995, 8:45 A.M. - 12:00 NOON
LIBRARY & COURTS II BUILDING
900 N STREET, ROOM 340
SACRAMENTO, CALIFORNIA

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:10 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:10 - 9:35 A.M. ***PRESENTATION #1:***

Bronwyn Mayden, M.S.W., the Director of the Florence Crittenton Division and Program Director, Adolescent Pregnancy Prevention and Parenting Services for the Child Welfare League of America. Ms. Mayden was formally the Executive Director of the Governor's Council on Adolescent Pregnancy in Maryland.

9:35 - 10:00 A.M. ***PRESENTATION #2:***

Katharine Heintz-Knowles, Ph.D., Assistant Professor, School of Communications, University of Washington, Seattle, Washington. Dr. Heintz-Knowles will discuss how children and teens are depicted in the media and the relationship of these depictions to teenage sexual behavior and pregnancy.

10:00 - 10:10 A.M. ***BREAK***

10:10 - 11:00 A.M. ***STATE DISCUSSANT PRESENTATIONS***

Colleen Stevens, M.S.W., Chief, Media Campaign Unit, Tobacco Control Section, Department of Health Services. Ms. Stevens will describe the anti-smoking media campaign and factors relevant to designing an effective teen pregnancy prevention media campaign.

Julie Linderman, M.P.H., Health Education Consultant, Office of Family Planning, Department of Health Services. Ms. Linderman will describe the media component of ENABL (Education Now and Babies Later).

11:00- 11:45 A.M. ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

11:45 A.M. - NOON ***WRAP UP***

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POLICY ROUNDTABLE #2

TEENAGE PREGNANCY PREVENTION STRATEGIES AND THE MEDIA

Campaign For Our Children, Bronwyn Mayden, M.S.W.

Now with the Child Welfare League of America, Bronwyn Mayden was selected a number of years ago by the then governor of the State of Maryland to design and implement a comprehensive teenage pregnancy prevention program. It was one of the first recognized programs in the country with a strong media component, Campaign for our Children. She will talk about how this component fits within the broader context of a comprehensive teenage pregnancy prevention strategy. She will also show us some videos and radio spots.

Thank you. I'm really pleased to be here once again. Because I have spoken once before to state policymakers about teenage pregnancy media campaigns, I decided to do a little more research looking at the media and what are some of the components of good media campaigns. I think many of the comments of today's speakers aren't limited to sexuality issues. You can apply them to other issues like alcohol, drugs, and tobacco.

I think the other message that all of us want to make is that none of us are saying that a media campaign is going to solve any of our problems. For anyone to come before you and say, "Purchase or use my media campaign and you will see a decrease in adolescent pregnancy or childbearing," is foolish. Don't let them fool you into believing that you can do something like that, put on TV and radio spots, and think that you are going to have an impact. It is one strategy in what I like to think of as our arsenal of weapons we use in teenage pregnancy prevention. It is merely that: it is a strategy, it is not a program. Actually some of the best research that we have from media programs really shows that when it is planned and executed correctly and you put in place along with it other hands-on programming, you can begin to see some impact.

So what I would like to do for you today very briefly, is to talk about what we did in Maryland and also put it in a broader context in terms of what do we know about the media. I will also discuss how we can begin to harness the media and use it for what we want -- to really promote a healthier lifestyle for young people.

Let me tell you a little bit more about Maryland. I think it is important that you know about Maryland because the media that you will see -- and I brought with me different spots -- really reflects my state. They do not reflect your state. The state of Maryland has a population of about five million; approximately 69% Caucasian; 28% African American; and fewer than 30,000 Hispanics. It is a very small state. It is primarily a very urban state. In Baltimore City, the population is very dense. Almost 65 percent of the residents in Baltimore City receive some type of public assistance. We have some real pockets of poverty in the state of Maryland. However, for the entire state the per capita income is ranked seventh in the nation.

Baltimore City is very poor, and has, of course, some major problems not just what I said in terms of income, but also fewer than one-third of the kids that start high school will not graduate. The economics of the city of Baltimore have changed dramatically. Try to put in context the problem of teenage pregnancy. In the 1950's the biggest employer in Baltimore City was Bethlehem Steel. Even if a young girl got pregnant at a very early age, in 1950, the young man would marry her. He could drop out of school and get a job, work at Bethlehem Steel, and make a good income; he could put that kid through college if that's want they wanted, and own his house and have health insurance.

But now in 1995, the biggest employer in Baltimore City is Johns Hopkins, a very high tech medical institution. To work at Johns Hopkins you need at a minimum, a high school diploma even to sweep the floors there. So what does that say in terms of economics? It tells us that it is also an economic problem in terms of adolescent childbearing in that these young people drop out very early and they cannot get jobs. It is not just teenager parents. Young families still are not that prepared either, when they drop out. They have no marketable job skills.

In Maryland, we began our work with a commission, just like every state that decides to look at the issue of teenage pregnancy, and they issued a report in September of 1985. That was well timed because our General Assembly starts January and runs through April every year. The report provided eighteen major recommendations and from the recommendations three teenage pregnancy prevention legislative proposals were submitted to the legislature.

The first bill was to establish a governor's council on adolescent pregnancy, an umbrella organization that would work with state agencies to help plot out what we should do about teenage pregnancy, and develop an action plan that got state agencies working together. We had a lot of policies and programs that were working at cross purposes in our state. In addition, the legislation said the council ought to monitor progress of pregnancy prevention efforts, conduct evaluations, guide communities as they develop programs, work with the private sector, to involve them in adolescent pregnancy prevention. And that is how we began working to develop the media campaign.

The second piece of legislation that was developed and passed called for a media campaign. It was very clear it was an abstinence-based campaign for young people. It was passed and was funded at $100,000. It was not a lot of money to do a media campaign, all of us now realize. Except I didn't realize this when I started working on this in 1988. That was how naive I was.

In addition to that, there was a third bill. It was an adoption bill, and that bill failed.
The funding for the media campaign was placed in the State Health Department but after several false starts, the media campaign was sent to the Governor's Council for us to develop. It was at this point I stepped in, met with one of the largest media firms in the state, and asked them to develop a media campaign that would be aimed at young people to get them to delay sexual intercourse. The CEO of the firm was incensed that the state of Maryland would use taxpayers' money to do something such as a media campaign for a problem he thought was so broad and persuasive, knowing that with only $100,000 we would get nothing, we were just

wasting the taxpayers' dollars. He then came back to me and said, let's sit down and talk. This was the beginning of a public/private partnership. The reason why I like public/private partnership so much is that I am sick and tired of government feeling it can "solve" these problems on its own. We are all in this together. Some of our commercials in the media campaign actually say that to the public.

Consequently, we decided to develop this media campaign. Now, we did a number of other things besides the media campaign. It is important for you to know that. The media campaign was what we called the first strategy that we put out there to the public. We wanted to get kids to delay sexual intercourse. It was aimed at kids 9 to 14 years of age, a little bit different than the age group in ENABL. It is a great goal. It is a message that everybody in this room could agree on, that you don't want a kid at ten years old being sexually active and having sexual intercourse.

The second strategy is to get young people who are sexually active linked up to family planning services. We did that by providing the services everywhere we could, including school based clinics. Baltimore is one of the first places to have school based clinics and also one of the first places to introduce contraceptives without a whole lot of brouhaha and nastiness that goes on in the other communities.

We also have parent/child communication programs going on as a third strategy. And equally important is funding for such efforts as community incentive grants for the communities to get involved and develop their own pregnancy prevention efforts.

Let's talk a little about the media campaign. Working with the media firm, we decided to develop a five-year campaign. We couldn't do it in one year. We needed a long stretch of time to get the message in front of the public, and to evaluate it. We only had $100,000 for one year. That was the first problem that we had, we only had a little bit of money. We decided to aim the message at pre-adolescents, aged 9 to 14 years of age. Why? Looking at the vital statistics in Maryland, we found a couple of things: one is that we were beginning to see 11-year-old, 12-year-old girls getting pregnant and having babies in our state. We knew that we needed to reach them at a very early age with the message to delay sexual intercourse because they were still at an age where they listen to adults and they listen to their parents. Something happens when a kid reaches adolescence and all of a sudden their hormones or whatever kicks in and they know more than all adults. They take a lot of risks. For us to design a campaign that spoke to a kid in high school to say, "Don't have sex," is, I think stupid and a waste of money.

Consequently it was aimed at very young teenagers. Also we were aiming the campaign at another objective, trying to decrease the time period between initiating sex and using contraception. Once they become sexually active it takes them eleven months to get to a family planning clinic. We wanted to decrease that as much as we could, get it close to zero. We wanted to market some messages to the community. We wanted to increase the knowledge and change beliefs that impede the adoption of healthy attitudes and behavior. We

wanted to teach new behavioral skills, stimulate interpersonal communication and win the support of opinion leaders, our legislators. So we had an ambitious agenda with $100,000.

What did we do? At the urging of the media firm, we formed a nonprofit organization, which was the smartest thing that we could do. All of us know the bugaboos of trying to work with government and trying to be creative and innovative. We also formed a nonprofit because we had to fundraise.

After discussion with the Governor and the response from the legislature and the public the funding went up to $320,000 annually, which is what it still is. The nonprofit, you need to know, has gone out and fundraised approximately $5 million. Why would anyone give money to a campaign such as this? Because we knew that businesses were not going to have workers that were able to read and write. It is interesting because we were saying this in 1988 and people were laughing at us.

We did develop the long-term strategic five-year plan. We knew that when the five years were up, we were going to the governor and ask for another five years, which we did do and he approved. We are now in almost year nine of the campaign. We wanted to develop a plan that would be based on analysis of the problem, like who has the highest need. We did research focus groups. Can they be reached through available media methods? What media methods should we use? Television more than radio? What behaviors should be promoted and what efforts are needed to change the behavior and increase awareness and knowledge?

The campaign focus was on the pre-adolescent as well as the adolescent because kids are beginning sexual intercourse very, very early in age. We also decided to target the parents because at that point they still exert enormous influence over their children at that age. Also, several messages encourage parents to have discussions about sexuality issues and be the primary sexuality educator of their kids. The same thing about alcohol, sex, drugs, and on and on. Parents need to be taught how to recognize whether their kid is sexually involved or whether they are using alcohol or drugs. We ought to work with parents so they should enforce rules. They should really have rules about what's going on, about parties, and behavior and that type of thing. These are the values that I bring to you today.

Parents also should become advocates for policies, to really look at some of the policies of the state government in terms of what we are trying to do with young people. Also, to participate in other community based efforts to help strengthen them and to work with them.

What are the campaign messages? We went through several phases of messages. Our material speaks to kids as a target group and says to kids: "It is okay. You are not a nerd. There is nothing wrong with you if you decide not to have sex." We wanted to give that message to them over and over and over again. And our first wave of material gives that message very strongly. It also showed kids what happened to them once they got pregnant in terms of basically being alienated at times from their group by their peers. Also a media campaign should emphasize what are the benefits, and you will see that in terms of dreams and

that type of thing. The target audience should be shown the immediate high probability of consequences of their activities.

We use peer models as spokespersons and not adults. The celebrity spokesperson was never used and we don't want to use them. In 1988 when we started, we toyed around with the idea of the celebrity spokesperson, however, since you can cannot control the behavior of celebrities it is difficult to use them.

We also strive to stimulate interpersonal behavior. Also, we did a lot of pre-testing. I can't emphasize that enough. With that, I'd like to play the television spots first, then the radio, and finally show you posters.

(From the television)

TV Ad #1:
(father speaking to son) "While you are in my house, you live by my rules. Don't be staring at your feet, you know what I'm talking about. You and Debbie. If you get a girl in trouble, you're going to have to do the right thing. Then you know what you can look forward to, babies crying all night long, dirty diapers. If you are going to have sex, you better be ready to be a father. You can't even keep your room clean." (narrator) Talk to your kids about sex. If you need help, call this number.

TV Ad #2:
(mother to daughter) "Don't give me that look. You think you invented sex? Listen, my sister got pregnant when she was 17. She quit school, she lost her friends, she was alone. You think that boy you're seeing is ready to be a father? Wait, honey, please wait. Nobody's saying sex is bad, but to a 13 year old, it will kill your dreams." (narrator) Talk to your kids about sex. If you need help, call this number.

TV Ad #3:
(narrator) (Baby crying) "If you get pregnant, this is what the rest of your teenage years are going to sound like. Being a father when you don't go all the way." If you need help, call this number.

TV Ad #4:
(narrator) "An epidemic of teen pregnancies is ravaging this nation. Even more disturbing, many of these little girls' lives are not being ruined by boys, but by 20-, 25-, and 30-year-old men. If you think having sex with a 14 year old makes you more of a man, you obviously don't understand the meaning of the word."

TV Ad #5:
(coach to players) "Listen up. You think if you get a girl pregnant, it's her problem; right? Wrong. For you, it's all over. All she wrote. Even if her brother doesn't come looking for you, do you think I'm going to let you play like nothing happened? You'd be lucky to finish high school, never mind college. Start thinking with your head. You may be old enough to

do it, you aren't old enough to handle it." (narrator) Talk to your kids about sex. If you need help, call this number.

TV Ad #6:
(young male) "My girlfriend dumped me. Do you know why? Because I wanted to have sex and she didn't. What's her problem? I told her, Guys are different. They need it. And if she really loved me, she'd show me. Everybody does it. It's no big deal. I mean, you want to be a virgin forever? Anyway, she said she found someone who doesn't push her. Do you believe that? Someone who is nice. Do you believe that? What does that make me?"

TV Ad #7:
(young male and female) "Come on, everybody does it." "Not me." "It's no big deal. Do you want to be a virgin forever?" "You just don't get it." "Where are you going?" (narrator) Teach your kid, it's not a dirty word.

TV Ad #8:
Question: "What do you call a guy who makes a baby and then flies the coop?
Answer: (chicken noises) "Now you see him, now you don't. If you are going to have sex, be ready to go it alone."

(From the radio)

Radio Ad #1:
(narrator) "School is out for the day and all across America almost 2 million kids go home to empty houses. What are these latchkey kids doing after school? Many are involved in sports groups, others have part-time jobs. If you are a lucky parent, maybe yours have started dinner. But unfortunately for many of America's children, these hours aren't spent in the kitchen, but in the bedroom." (adolescent) "Got the house all to ourselves, baby." (narrator) "Today nearly half of America's 15 year olds are sexually active. What's more, every 67 seconds an unwed teenage girls gives birth. These statistics cut across social, economic, and racial lines, and point to one important fact: If you don't talk to your kids about sex and give them the information they need to make the right decision, then the combination of motive and opportunity might be too much to resist. It's 3:00 p.m., America, you may know where your children are, but do you know what they are doing? Talk to your kids about sex because silence breeds babies." Brought to you by Campaign for our Children.

Radio Ad #2:
(narrator) "With a long list of issues facing us in the '90s, the problem of teen pregnancy might not be considered a high priority because it doesn't present the immediate threat of drug abuse or street crime. It doesn't carry the desperation of the homeless. Some men and boys might not even consider it a problem. The fact is, we won't be able to win the war on anything until we win the battle of teen pregnancy. When a child has a baby, he starts a cycle of poverty and low self-esteem that lasts for generations. Illiteracy, child abuse, drugs, all start here. The cost is staggering. On the national scale, teen pregnancy costs taxpayers $34 billion a year. That's enough to hire 984,000 more teachers, build 1478 more schools, feed

27.2 million meals to the homeless, all without raising taxes. The good news is you can help fight teen pregnancy. Parents, teachers, counselors, clergy, talk to your kids about sex. Make it a priority. Give them the information they need to make the right decision. Because when a teenager gets pregnant, we all carry the child." Brought to you by Campaign for our Children.

What we are trying to do is surround the young person with our media messages, as well as our programs, so that when he got up, was getting ready to go to school, when he turned on the radio, he would hear our commercials played on teenage-oriented radio stations. Not the commercials that I just played for you, but I have some others that have the music that is kind of hip. Then when a young person leaves his house and goes to school, we have billboards that are up in the community that say, "Virgin. Teach your kid it is not a dirty word." And we have chicken posters. That has also been made into billboards. We have bus placards, and then these posters that speak to the issue of what we call male responsibility.

To keep a media campaign fresh, you really need to have different themes. Male responsibility is one theme that we do. "Talk to your kids about sex" is another one.

In campaign implementation, you really need to select vehicles that get the attention of your target audience. Consequently, we were on during a lot of Fox TV shows. We paid for the air time. But we were very creative in that we didn't pay the same rate that Coca-Cola would pay, because we couldn't afford to do that. We had the TV station work with us as partners. We made them partners so they saw this as basically their campaign also. We also did a media plan that was based on audience rating shares. We knew when our audience was looking at TV and we were on during prime times and all year round. At certain times we are on the air more so than others.

We looked at our birth certificates and most babies are born in my state in September. So we backed it up nine months. And we figured maybe kids were getting pregnant in December, in school break. So if you come to Baltimore around then, our commercials are played that quite a bit then.

Then the final thing is evaluation. How do you try to evaluate something like this? After we started this program the first year, the numbers and the rates kept going up. I was called on the carpet a number of times by the governor who was very concerned. He was pumping out this money for this as well as a lot of other programs and the rates were still going through the roof. Fortunately, by the third year we started to see a downward trend which has continued. We have worked with two different research teams from Johns Hopkins. They haven't been able to isolate the media to determine how the media campaign impacted the behavior of young people. This is because we have so much going on in terms of public programs and strategies in our community. Adolescents may go to a school with a school based clinic and consequently they may be getting family planning services. But those were the types of problems the evaluators ran up against. Since we weren't paying them, they walked away without what I call hard data. We do have baseline data from a thousand kids. We went to the malls all over the state of Maryland and got baseline data to find out whether they knew

about the campaign, could they understand it. Again it was a way for us to test whether this was reaching our target population. Had they seen it? When did they see it? We knew that we had played in certain markets and if somebody said they saw it, they in fact saw another campaign.

The Depiction of Children and Teens in the Media and the Relationship to Teenage Sexual Behavior and Pregnancy, Katharine Heintz-Knowles, Ph.D.

Dr. Heintz-Knowles will talk about her work at the University of Washington and will also comment on the Children Now study that she recently completed analyzing how children are being depicted in the media. She has a lot to contribute about what the state of Washington is doing in teenage pregnancy prevention using the media and the whole topic of how one constructs a media strategy.

My other copresenters are going to talk about how the media fit in the context of larger public advocacy or public information sharing, but I'm going to talk about how the media components of those efforts fit in the larger context of children and adolescents in the media. I want to talk about how much and what kinds of media children and adolescents use and then the kinds of messages regarding sex and sexuality that we know that adolescents use and respond to. I will talk a little bit about responses as well.

As Bronwyn Mayden pointed out, one of the many messages that they are trying to promote is talking about sex. For teachers, parents, counselors, clergy to talk to kids about sex. And we know that many, many people and many kids don't have any place to turn for information about sex except the media. And the media, especially television and movies, have no problem providing ample information about sex and images and discussions of sex and sexuality. We know that when kids learn from media messages, the kinds of media messages that are the most useful and have the most impact on children and adolescents are ones that are relevant. If the information is relevant, it is more readily learned. If the information is perceived as realistic, it's more readily learned than if it is perceived as fantasy. If it is frequently repeated, it is more readily learned. So relevance, realism and repetition are key. These three really combine to make messages very powerful.

Sexual messages and adolescents are a volatile combination because you've got adolescents who are becoming very interested in sex, so this information becomes very relevant. They also don't have a lot of real world experience with sex, so they have no way of contextualizing whether or not the images that they see in the media are realistic. How do those compare with the kinds of behaviors that they are going to perform, that their parents perform? They have no idea how to really judge the reality and the realism of behaviors. And they see a lot of sex in the media.

Let me tell you briefly what we know about adolescents' media use habits. We know that broadcast television and radio are available in 99 percent of American households. Cable television is now available in about two-third of American homes, but for households with children, it is about 75 percent. Video cassette recorders (VCR's) are now available at about that same level.

One of the things I want to touch on is the scheduling of television programs. Some people take heart in the fact that some offensive programs are aired during school hours so the kids don't see them. But the VCR completely negates any sort of scheduling time. It doesn't

matter when programs air, because kids who want to see them will tape them and watch them when they get home from school. It is because of the VCR that television station schedules are irrelevant.

It is not unusual for American teens to have TVs and radios in their rooms. We know that about half of America's teens have television sets in their rooms, and often those are connected to cable. So they are getting broadcast and cable television in their rooms. We know that television viewing levels start to drop off at about age 12, but they don't drop very much. Nielsen estimates from last fall say that elementary school children watch approximately five and a half to six hours of television a day. Just about the entire waking hours that they are not in school is spent with television. For adolescents it has dropped slightly to about three and a half to four hours a day. American adults average four and a half to five hours a day. That means that two entire months are spent in front of the television each year, an enormous amount of time.

Adolescents generally view alone or in the company of their friends. They don't like to watch with their parents, their families or their siblings anymore. You find that television is a family event for children, but not for adolescents. They really like to watch alone, and having televisions in their rooms makes that a lot more possible. Accompanied with the drop in television viewing at about age 12, we see an increase in music listening. Adolescents listen to music between two and three hours a day. It generally accompanies other activities and isn't a solitary activity. This doesn't include MTV, which is counted as TV time. So if you add it all together, the approximate media time for an adolescent during the day is five to six hours.

Movie attendance for adolescents is also high. They are the highest movie attending group. They average 1.5 to 2 times per month and prefer R-rated movies to any other rating of movies, both at the theater and on cable. With the VCR they also have access to R-rated movies.

We know that adolescents spend a lot of time with media, but the question is what are they seeing, what kinds of messages? Last fall, I was commissioned by Children Now, which is an advocacy organization based in Oakland, to do a study of the values and the behaviors and the goals of children on television. I have to very clearly specify that these were children, up through high school age. What Children Now wanted to know is what are the things that kids on TV value and what do they do, what kinds of behaviors do they perform to obtain their goals? They wanted us to look only at entertainment programming, so we decided to look at just series programming because we wanted the consistent messages. Made-for-TV movies certainly talk about or send a lot of messages about sexuality, about adolescents, to kids, but we wanted to look at what they see day in and day out when they watch -- Roseanne or Home Improvement or Mighty Morphin Power Rangers -- and what kinds of messages are they getting about relationships and about behaviors.

We selected nine television stations, the four commercial broadcast networks, the public broadcast service, USA channel, Nickelodeon channel, Disney, and then we also selected other programs that are available through syndication, not produced by any specific network

or television station. We ended up looking at 499 different child characters. We videotaped three episodes of 75 different programs, so we analyzed 109 hours of programming. I didn't watch it all, thankfully. I was, however, lucky enough to get California Dreams as one of my programs, and Power Rangers. We looked at programs ranging from Home Improvement and Roseanne and Picket Fences to the Power Rangers, Lamb Chop's Playalong, Legends of the Hidden Temple, Wild and Crazy Kids. We looked at animated and live action characters, only depictions of human children. We didn't analyze the Ninja Turtles, even though they are teenagers, and we didn't analyze Muppet Babies. We only looked at humans.

One of the primary questions was, What motivates children on television, what are their primary goals? We recorded the primary and secondary motivation for each child in each episode and tabulated this all. We discovered that the primary motivator for children on television is to establish or maintain nonromantic peer relationships. Above school, above family concerns, above societal concerns, they are most concerned with establishing and maintaining friendships. Over half of the children in our sample had that as their primary motivation.

The secondary motivation was establishing or maintaining romantic relationships. The third motivation was maintaining family relationships, but it fell a distant third. So we know that children on television are primarily motivated by the desire to establish and maintain nonromantic and romantic relationships. This is also a primary motivator in the real world. We are not saying that these are very unusual kinds of depictions. Except what is really interesting is that if you look at the children on television, they are concerned with almost nothing else. They have no awareness of the wider world and their part in it. They have almost no issues regarding school. They have almost no issues regarding religion. They have very few other concerns besides friendship and romance. The children on TV have little more to worry about than getting a date to a dance or making sure they don't wear the same dress as the nerd to the prom. They want to make sure that they have the appropriate romantic and friendship relationships.

These are very unrealistic depictions. The entertainment industries often comment that these are art, that television is for escape, so why should we burden kids who are having problems in school and are having other kinds of problems with those kinds of problems on television as well. In the one sense, you can agree with them and say, yes, it is a nice escape. But on the other hand, for children who do look to television for some sense of who they are and for guidance and coping strategies, they are offered almost none from television.

Children Now also commissioned a survey at the same time as my content analysis study, and it was very interesting. They surveyed 750 10- to 16-year-olds across the nation and asked them questions about television, how realistic was it, how useful was it, how much they liked the images on television? They found that the younger kids in that group mostly said they liked television and they thought television provided good role models for kids. But what I thought was very striking in the data was the older children, among the 15- and 16-year-old girls, not boys, less than half of them agreed there was enough good role models, and they

didn't agree that girls and boys were portrayed equally on television. The younger children agreed that they were, but the older children didn't.

In conversations with some of these girls, what we found out is that they were saying they don't appreciate these very unrealistic and trivial representations of relationships. They wanted something that was more realistic. They talk about programs like The Real World, on MTV, which is a reality program. They talked about My So-Called Life, which has been canceled by ABC and has been picked up by MTV. They talk about those programs as fulfilling their needs, talking about realistic difficult teenage issues. They say they don't appreciate many of the other programs that deal with trivial issues or deal with sensationalized traumatic sexual issues, that it frightened them. A number of the girls said they were afraid of being stalked. They said they were afraid of being raped by a stranger, they were afraid of being duped into a baby-selling business. They were afraid of these very far-out kinds of sexual terrorist acts because of the high frequency of these kinds of representations in made-for-TV movies, on TV talk shows (which are very popular among adolescents), soap operas, and on tabloid news shows. This is the stuff of those kinds of programs, and they perceive these as being very frequent occurrences and things that could potentially happen to them, things they need to worry about.

On the one hand they are getting absolutely trivial material about sex and relationships or they are getting very horrifying information about sex and relationships. There is almost nothing in between that responds to what their lives are really like.

We then looked at the behaviors that children performed. We looked at their motivations, we looked at their behaviors. We were quite surprised, frankly, to find that the frequency of performance of sexual behaviors was pretty small. Everybody is talking about kids and sex and all of the sex on television, but minors on television don't perform sexual behaviors very often. We found about only 104 acts that were coded as sexual acts out of about 1800 acts of behavior. So it is about 6 percent of our behaviors. The most frequent type of sexual behavior performed by the kids on TV was kissing. That accounted for about a third of the sexual behaviors. The second most frequent was flirting, sexual innuendo, sexual conversation. Verbalizations of sexual ideas made up about another third of the behaviors. There was only one instance of sexual intercourse, implied sexual intercourse, in the whole 109 hours of programming. It appeared on a program called Party of Five.

But it is important for me to mention here that we did specifically take our programs from nonsweeps months. If anybody knows anything about television, all or most of the sex happens during sweeps. We wanted average programming, so we did the month of October (sweeps are in November). We didn't get any of the episodes that were distinctly promoted as the sex episodes, you know, the Fresh Prince is going to do it, Blossom is going to think about doing it. So there are several episodes where you do get teens who talk about it and think about engaging in intercourse, but we didn't get any of those episodes in our sample, except the Party of Five episode.

Even though we didn't find a high frequency of sexual behaviors, there are a couple of things that came out that, I think, are really important when we talk about learning about sexuality from television. Kissing and caressing, the physical displays of sexual behaviors were limited to high school students in our sample. We didn't find any of the TV characters younger than high school age performing sexual behaviors, kissing and caressing, but we did find that children from all age groups engaged in flirting, engaged in sexual innuendo, engaged in other kinds of sexual conversation. It is not at all unusual. If you look at television it is not at all unusual to see five- and six-year-old TV kids dressing up and posing for members of the opposite sex, commenting on the appearance of other children in their first grade class, commenting on the appearances of adults. It is not unusual to see this happening in preschool television children and elementary school age television children. They appear to be very sexually sophisticated. They say very sexually sophisticated things on television.

I think this has some really important implications for viewers. I think if children repeatedly see these images -- and young children watch anywhere from four to six hours of television a day on average, and we know there are some who watch eight hours of television a day -- they may come to believe that they too are supposed to be interested in sex or interesting for sex with others, before their bodies are sexually mature. I think this sends out a very dangerous message.

I think for adults repeatedly seeing images of children as sexually sophisticated can send a dangerous message. If older children or if adults perceive that children as young as age 10, we're talking about 8, 9 and 10, are sexually sophisticated and sexually willing, this is also sending potentially dangerous messages. I think these kinds of messages are the ones that we need to be concerned about.

We found another interesting pattern in our analysis of the behaviors. We looked at whether or not the behaviors the children performed were goal related. We have a whole host of these figures in the report. It was primarily violence that we focused on. But we wanted to see whether or not children used these behaviors in order to achieve these goals, and if they did, were they successful. When we looked at whether or not sex was used to achieve a goal, we found that, generally, sexual behaviors were not goal related. But when they were, girls were twice as likely as boys to be successful. Girls were frequently shown using sex to get what they wanted. Boys tried, but they didn't get what they wanted.

A very common theme if you watch any of the teenage programs like California Dreams or Saved by the Bell, very commonly you will have a girl who asks her boyfriend to do something he doesn't want to do, something like in one episode she wanted him to dress up like a clown to entertain some children and he didn't want to do it. In another episode somebody asked her boyfriend to try out for the school play, and he didn't want to do it. Or to do something like help a teacher who nobody likes. So the boys are risking their fear of humiliation. Then girls are shown giving a long kiss and the boy becomes glassy eyed and begins acting like a clown or begins performing the behavior she wants. Or you'll see some sort of whispered promise of some sort of sexual reward later which easily convinces the boy to perform the behavior. You often see boys are portrayed as animals who will do anything

for the promise of some sort of sexual fulfillment. The girls know it, so the girls are shown using their sexuality in order to achieve their goals, as a means to their end. The boys generally have sex as the end, not the means.

When we think about the kinds of role models that are presented, when push comes to shove, even the girls who are shown as intelligent and capable still use their sexuality. They know that that's going to work, even if they can't convince them by using logical argument. This is also common in all the characters on Melrose Place, and on Beverly Hills 90210. Soap operas often show these kinds of images, these same patterns. We often see these same storylines over and over again and they are frequently used over and over again. We are sent the message that men and boys are sex-obsessed and that they are easily manipulated and that women know how to use their sexuality and that it works.

As I mentioned at the beginning, this particular study looked at what children on television do. If there's any truism in television programming, and there aren't many, one of the things we do know is that children watch up. That's one of the things that network executives talk about a lot. That means that children like to watch people who are older. Adults will watch the teenagers to see what is going on, but you find more often young children watching teenagers and you find teenagers watching young adults. And they look to see what they can expect when they get to be a little bit older. Even though we found only 6 percent of our behaviors was sexual, it is not surprising that the Children Now survey found that there was too much sex on television, too much sex before marriage on television. Sixty percent of the children of that survey claimed that they and their peers are influenced by what they see on television, that sexual messages on movies and TV do influence them and their friends to participate in sex before they are ready, while they are too young. They are obviously not watching the shows we looked at.

What I want to do now is contextualize what the children on television do into other studies of what other adults on television do. The kinds of programs that are most popular to older children are soap operas, music videos, prime time situation comedies like Friends and Seinfeld, prime time dramas like Melrose Place and Beverly Hills 90210. And all of these feature young adult characters, who are mostly unmarried, and very frequently have sexual themes.

There have been studies conducted in the late 1980s and the early 1990s and they found some very consistent patterns. I would like to just run through some of those. On soap operas, the most frequent sexual behavior is unmarried intercourse and long kisses. The most common participants were people who are married to someone other than their current sex partner, so they are married but just not to the person they are having sex with. This is different than on prime time programming. The same kinds of activities are most frequent, unmarried intercourse and long kisses. On prime time you see prostitution occurring with some frequency too, not a tremendous amount, but you do see it coming, especially in crime shows where the detectives pick up prostitutes or they have a theme regarding prostitutes. But on prime time programs we generally see the most frequent participants are not married or whose

marital status is unclear or are not married to their partners. Seventy percent of the people engaging in sexual behaviors on prime time are not married.

Most of the sexual activity on TV is verbal. That's something we should recognize. It's not visual on most of these. In the movies, on the other hand, and especially the R-rated ones, there is a lot more visual depiction of sex. In R-rated movies, which most frequently are the most popular viewed by the adolescent, sex is more frequent. R-rated movies are 32 times more likely to show unmarried intercourse than married intercourse, include virtually no discussion or utilization of contraception, and almost never shows pregnancy or disease as a consequence. Two of the really key components are planning and consequences. You have got to talk about consequences and planning. Sex in the media is spontaneous. No one talks about their previous sexual histories. No one talks about contraception. Regardless of that, there are virtually no consequences in terms of pregnancy and other diseases.

In fact, sex is often paired with aggression. We frequently see sex and aggression paired in music videos, as well as R-rated movies. R-rated movies actually have more sex and more aggression paired with the sex than do X-rated movies, which tend to be primarily sexual and without the aggressiveness. Sex and aggression is a real problem when you look at studies of effects. We know that people learn from media messages. When you look at sex, people learn about different kinds of sexual activities. Adolescents learn about the frequency, and often overestimate the frequency of unusual kinds of sexual activity that they see in R-rated movies. What happens when you pair sex and aggressiveness is we see increase in adolescent callousness towards women, decrease in the importance or impact of rape and various other crimes. In studies involving simulated rape trials, people who have been exposed to aggressive sexual messages often tend to give lighter sentences, tend to blame the woman more, and say she wanted and deserved it, than do people who didn't see sexually aggressive messages. So sex and aggression pairing, which is very frequent in the kinds of media adolescents see, is very alarming. There aren't as many negative consequences from viewing just sex as there are from viewing sex and aggression together.

One last thing we should be thinking about when we talk about sex is not just the sexual behavior, but also the sex roles and the different ways from very early ages boys and girls are cast in television programs. Are girls shown as capable, are girls shown as saying no to anything? They don't want to try out for cheerleading, are they allowed to not try out for cheerleading? Or are they always shown as willing participants? Are they spectators or are they actors?

One of the most egregious forms of media that shows sexual stereotype are video games, which are very, very popular with young boys and young adolescents. A very common theme is where a female is kidnapped and held hostage and the male must go save her, must rescue her. And certainly girls will play the game and can manipulate the male character, but there are very few female heroes in video games. I recently learned that the people from Sega Corporation (a video game company) want to open this market to girls, so they are creating more games with female heroes. But right now, video games are tremendously sexist. That has implications as well for a finding that girls are not becoming as computer literate because

the programs and videos are not geared to them. So we need to be thinking about sexual role imagery as well as sexual imagery in the media.

California's Tobacco Control Program and its Relevance for Designing a Teen Pregnancy Prevention Media Campaign, Colleen Stevens, M.S.W.

Colleen Stevens is with the Tobacco Control Section of the Department of Health Services. She has been involved in the media component of that, since the enactment of Prop. 99. Prop. 99, a 1989 voter initiative, increased the tax on cigarettes by 25¢ a pack and dedicated the revenue to tobacco education, prevention, and medical care. Colleen has been with the Tobacco Control Section a few years, beginning with being responsible for hiring the first advertising firm. Colleen will discuss what she has learned from the tobacco media campaign and its potential application to preventing teenage pregnancy.

As mentioned, in 1988, there was a voter referendum (Proposition 99) that added 25¢ tax on each pack of cigarettes. That money was dedicated to a special fund for tobacco use prevention and medical care. Approximately 70 percent of the money goes to medical care, with 20 percent dedicated to health education to stop tobacco use.

In the first few years, the tobacco tax brought in about $500 million annually. The health education component ended up being about $100 million a year. That money was divided between several program components: funding tobacco education through county health departments, the school system, and competitive grants at the local level, many of which targeted California's ethnic communities. The media campaign was the very last component to be added to that overall mix of programs. There was a long fight to get the initial legislation that started this tobacco control section through the legislature. All the predictors said the media campaign was the most vulnerable of the program components, and the next time the legislature reauthorized the program, the media campaign would disappear. Therefore a lot of our decisions in terms of how we framed the media campaign came from the fact we thought we were only going to have a two year opportunity to do the media component and after that it would never be seen again. One becomes a risk taker when you know you have two years and it is the one chance you have to make a difference.

The allocation for the media campaign for the first two years was $28.6 million. Currently, the allocation is about $12 million per year. Because California is a leader in media and entertainment industries, we have different rules that apply to us that other states can work around, that we are not allowed to work around. They make us do things in a different way because we are the media capitol of the world. Just buying media time in Los Angeles, which is the largest media market in California, is an incredibly expensive thing. So you have to put that in perspective in terms of what costs are in other states.

That same $28 million would probably cover Washington, Oregon, Nevada, Idaho and Arizona for two years. So it is not really easy to compare the dollars when you look at the costs in California.

Having a media campaign was really appropriate, especially when you consider the backdrop against which we have to compete. We have the tobacco industry which spends $6 billion a year, or $1.7 million per day, promoting the use of tobacco in California. They will clearly tell

you that none of that is aimed at children, although there is incredible brand loyalty with smokers and few people start smoking as adults. Even setting aside the argument of whether that advertising is aimed at children or not, you cannot spend $1.7 million a day promoting a product as sexy, glamorous, healthy, and everybody's who's cool does it, and not have kids see it.

So it was only right that we have a media campaign. From the very beginning we took as a strategy what the tobacco industry as a whole has done very successfully for 50 years. It normalized tobacco use. It's a part of our social fabric. We decided in our one shot at glory that our job would be to denormalize tobacco use and try to unsell a product, which is not a normal advertising challenge. At the beginning of the program, we really did a lot of formative research, and literature review, to determine the strongest direction for the program. Several things became clear from that research. Tobacco use is the number one preventable cause of death and disability in the United States.

Yet, even though the majority of Californians are impacted either directly or indirectly by tobacco use, most Californians were pretty apathetic about the issue. It wasn't a big deal issue. People who didn't smoke saw it as not their issue. People who smoked said, it's my choice and it's not an issue. So nobody was interested.

We did focus groups with both adults and children across the state. From the focus groups we learned that people knew the dangers of smoking, knew it caused lung cancer, they could give you back all the health facts, they could tell you what eventually happens to those who smoke. They already had the information, so it became very clear that giving people health messages wouldn't make a difference. So we focused our strategy on environmental change, and changing people's attitude about tobacco use, as opposed to going after personal individual change. Our program's overall goals are cessation, helping those people who want to quit to stop using tobacco and preventing people from starting to smoke. The majority of people, 80 percent, who start smoking are under the age of 18. Thirty year olds do not start smoking. So on the prevention side, it is almost all kids.

We concentrated on the environmental side and building an atmosphere where it would make it easier for people to quit smoking and less likely for children to take up the habit. We focused on three basic strategies:

- increasing people's awareness of secondhand smoke and decreasing their access or exposure to secondhand smoke;
- decreasing youth access to tobacco and availability of getting tobacco; and
- countering pro-tobacco influences in the community.

These same three priorities were also extended through our health department programs and our community based programs. They were complimentary programs and local priorities working synegistically with the media campaign. In the tobacco wars, we see the media campaign as the air cover and the local programs as the ground troops. We use the media to build an environment that makes it easier for the local programs to go in to do their job. The

media component raises people's awareness and the local programs provide the follow up. The media program by itself couldn't do it. The ground troops are there to provide services so when people ask for help, there is somebody they can be referred to for assistance. We think the strength of our program, what makes it work, is the combination of the statewide media with local interventions.

I am going to talk in a little bit about what I learned over the last five years in terms of what you need to think about if you're going to do media within a state bureaucracy. There are different rules that were alluded to earlier that apply when you are out in the public sector as within the state bureaucracy. The media campaign itself in the State of California for tobacco tax money has gotten incredible credit for all the change. There are actually people who believe that all the tobacco tax money goes to the media campaign, because it is the most visible component. Although about only 2 percent of the overall tax goes to the media campaign. People see it as the most visible element and therefore we get both the credit and unfortunately the hate mail.

Again, in terms of lessons learned and what I would do:

1) I would go out and hire the best agency we could find. We hired a regular advertising agency that was used to selling soap and Coca-Cola and all those things. We did not get a little shop that was just going to do social marketing. We really got an advertising agency and we ran the campaign from the beginning as an advertising campaign. We wanted to look at the problem from the advertising perspective. We tempered that with common sense and knowledge about tobacco use. We really wanted to hear what our advertising agency had to say and we took very seriously their recommendations, keeping in mind that advertising looks at issues differently than public health.

Public health says equal across the board, everybody gets the same thing. Give a service to one person, it has to go to everybody. With media you really have to get the most bang for your dollar. You have to get the highest level of awareness. If you make it so smooth and across the board that everybody gets the same, then nobody gets anything.

There are different rules. So we listened very carefully and applied media rules tempered with common sense that made sense working within a bureaucracy.

2) The Tobacco Control Section challenged our agency to come up with strong, impactful, clear messages. We didn't want to have messages that say, "This is the government, and we don't think you should smoke." We really wanted strong messages that would move people. If you get too watered down, it doesn't make a difference.

3) I would want strong administrative support. From the beginning we received good administrative support from Dr. Ken Kizer, Director of the State Department of Health Services (DHS), and from other people at the administrative level within DHS. When we brought the new creation that we were going to produce to them, they all sort of took a deep breath and said, Well, if it works with the target population, we'll let you go with it.

You can get bogged down if a bunch of overeducated, middle to upper class bureaucrats are deciding what's going to move the target population. And the target population in our case were kids and those with little and no education. So what appeals to somebody who has a Ph.D. or an M.D. is not the same thing as what is going to appeal to somebody who only has a twelfth grade or fourth grade education. So we really have to keep focus testing, we have to keep going back to the target audience and asking if this message is relevant.

The media campaign, because we got that good administrative support, started hard and strong and literally set the tone for the whole rest of the tobacco control program. We reframed the issues as to the way people looked at tobacco as an issue. I think that the programs, the local programs, actually went further and faster because of the tone set by the media campaign than if we hadn't done it the way we did it. Again, I think it was a really good synergism between the two.

4) You need to decide whether you plan to use paid or free public service announcement (PSA) advertising. We were able to use paid advertisement almost exclusively. That means you can put your commercial next to the show Melrose Place when your audience is there listening. You can place your message frequently, you can get it exactly the way you want it, as opposed to floating off into some infomercial in the middle of the night. To do the kind of campaign we did where we changed the environment, you have to have sufficient resources. You can't do one or two commercials and think it is going to change anybody's behavior or help the local programs. You have to have sufficient resources to get people's attention, for them to see the messages. If they don't see the messages, it doesn't do you any good.

5) In terms of the overall program, you need to remember teenagers are the hardest target population of all. It's much easier to get to adults and we've had incredible success with our target populations. Teenagers are hardest to get and you need to think of them as a long term investment. You cannot do a one-year campaign and expect to change 30 years of messages around pregnancy. You need to really plan on investing in kids and really working on changing their perception. You really need to change it all along the age continuum, at 8 and 10 and 12 and 15. If not, wherever you drop it off they are going to fall back in the previous behavior.

6) You have to be careful when you do a media campaign within a bureaucracy to not mix politics and media. While it's really great to have good political support, and I think this program is very fortunate because it appears to have bipartisan support, and a lot of people behind it in the political arena. When it comes to actually executing the media, if you worry about, "Is this a good time, in terms of legislation that is pending and you not wanting to say anything that might upset the apple cart or is not politically correct." If you get too bogged down in these concerns, then you really are going to lose your impact.

You need to know that what is going to get teenagers' attention is going to cause heat for whichever entity implements that program. You don't make billboards like those in Maryland did that say "Virgin" without getting nasty letters from people who say that's an inappropriate use of government money. It's almost impossible to talk about teenage sexuality without

making someone unhappy. That's a given. So even though it's great to have political support both through the legislature and through all branches of the government, when it comes down to doing the media campaign, it is not good for carrying somebody's personal political agenda forward.

7) You have to get credible, relevant spokespeople. I spent a lot of time studying other media campaigns, and you can't have political leaders being the spokesperson for your campaign. For example, having Kimberly Belshe´, who is the current Director of the State Department of Health Services, speaking to the *Wall Street Journal* about this issue, that is one thing. She is a credible, competent resource when giving an interview with the *Wall Street Journal* or other media aimed at adults. However, she is not as credible when she is talking about her experience and what it was like when she was a kid, and how it applies to inner city, high risk teens. This is a woman I have great respect for. But the issue is that you have to have someone that kids relate too, and most often that is other kids. So you have to get credible spokespeople for the people who are going to be hearing the message. If you are speaking to, again, the *Wall Street Journal*, you will get one kind of person. If you are doing commercials during Melrose Place, you will get another.

8) You must test, test, test and retest your messages to make sure they are on strategy and relevant to your target audience. Don't get enamored with what you created. Agencies come up with beautiful ideas and it's easy to fall in love with their ideas. You have to keep in mind, is it going to be relevant to the people you are targeting. You must stay at all times focused on your goal. You have to keep asking your agency and your yourself, "how will this ad move us closer to our goal."

Did it work? There are a lot of ways you can look at whether it worked. One way you can look at it is, did the people see the campaign? Did they get the message? Did people know it was out there? And for sure we can track and show that people saw the messages, they remember the messages, and we can go back to kids who can quote commercials we haven't ran for four years. So that is one area where we know it worked. What we can't say, is exactly what part the media played in changing California's attitudes about tobacco use. We can say people saw the commercials and can feed us back the lines. But we can't take a synergistic program with many elements that are working together in harmony and say, someone moved closer to quitting smoking because they saw a commercial rather than because they called an 800 number and got information. So dividing the parts in a synergistic program does not work. We do know the overall effect worked very well.

The National Coalition on Smoking and Health, which is a national group comprised of the American Cancer Society, American Health Association and the American Lung Association, and other advocates on behalf of tobacco issues nationally, gives a report card to states every year as to how they're doing. Two months ago, California received the first "excellent" they have ever given to any state ever. Not only because of the program, but the way the population has responded to the program. Our prevalence is down. The number of people smoking is down. Our last major study was in 1993. At that time the smoking rate (prevalence) had gone from 26.8 percent in 1988 to 19 percent in 1993. We have done two

smaller studies since then, and we know the trend is continuing to go down. Additionally, the actual number of cigarettes people are buying (consumption) has decreased by 41 percent. So the sales of cigarettes has gone down substantially.

People's attitudes about smoking in California five years ago and now have changed. You need only leave the state to see how much they have changed.

Lastly, I would say that those of us in education and public health who have messages to deliver to people need to make friends with the media, whether it is paid media or free media, we need to make it work for us. When people are watching five hours of TV a day, they are not reading books, they are not reading the newspaper. If you want to get messages to people, the media is becoming the best way. We are having whole generations of people who are growing up with television as their main source of information about most interpersonal relationships about life, and about health. I think that those of us who have issues we want to bring forward are going to have to learn to work with media and make it our friend. This is especially true when you think of the fact that in public health the people who most need the messages are disproportionately people who are poor, who are less educated, who have less access to the information. They may not go to school, they may not read, but 99 percent of people are paying attention to the media.

Education Now And Babies Later (ENABL) Media Component, Julie Linderman, M.P.H.

Julie Linderman is from the Department of Health Services, Office of Family Planning. Among other things she oversees the media component of ENABL.

Those of us who use media campaigns do not and never did intend that the advertisements on their own would change behavior. This is also true with the Education Now And Babies Later (ENABL) media component. The program started, not by saying that the television and the radio and newsprint would cause all young people to decide not to have sex until later, but that media is a useful support component of a comprehensive program. Education Now And Babies Later is a program that includes the direct education of young people in communities, school settings, and other settings where young people gather. It includes community activities to begin to shape (or reshape) social norms to support young people in postponing sexual activity. ENABL included additional components for evaluation of overall program; training to build a cadre of leaders who would implement education strategies and community action to encourage young people to postpone sexual activity; and coordination through the State Office of Family Planning and Department of Health Services. ENABL is a multifaceted program.

Education Now And Babies Later media component is not one single intervention. It is a strategically planned set of interventions addressing a segmented population, just as is done in commercial marketing. The segment this program focuses on is 12 to 14 year olds. For many reasons early adolescents are still forming behavior opinions and values. They are still looking for support in the decisions that they are making. They are highly peer influenced. It is known that youth who have not yet initiated sexual activity are more likely to be convinced to postpone that initiation than are youth who are already sexually active.

The focus on the 12 to 14 year olds was to intervene while there is still an opportunity to postpone the age at which sexual activity is initiated. The media campaign was designed from the very beginning to be a supportive element of an overall campaign. It was based on a three-year plan that was proposed by Governor Pete Wilson in his prevention agenda of 1991. Media activity in the beginning announced the campaign and created awareness -- a general public awareness of the problems of teenage pregnancy, and the need to do something about teenage pregnancy, and also a youth awareness that there is a way to avoid sexual activity. The media was used to generally creating more normalcy in the environment for the idea that young people do not have to become sexually active due to social, peer, and media pressure at a very young age.

The first fiscal period in which the Education Now And Babies Later campaign was funded was a compressed fiscal year. The governor announced the prevention agenda in his budget in January 1991. The legislature approved the funding in the budget effective July 1. The funding didn't become available for use until later on in the fall of 1991. It wasn't until November of 1991, that we could actually plan implementation.

Because of the manner in which we fund things through government agencies in California, we did have to go through a lengthy development and procurement process (request for proposals), to institute a media campaign. This meant that we actually began the implementation of the ENABL campaign, the activities at local levels, funding local contractors, training programs for local contractors in the community, and the media campaign in May of 1992. The fiscal year in California ends June 30th. Therefore, it was a very short first year of operation.

In the first year, we put a large share of the total program funding into the media campaign component because it was the component that could be executed in that short period of time (faster than we could train people in the community, get kids educated and get it all evaluated). In the second and third years of the ENABL program the ratio of component funding was inverted. That left in the succeeding fiscal years less money for media and purchasing air time; therefore, we didn't develop any new materials in the second and third years. The money was then being directed more heavily to the local education and local community activities.

ENABL used all the marketing strategies and approaches that have been enumerated by the other speakers here today. A great deal of attention was paid to whom we are sending a message and what could be the usefulness of the message. This campaign is not selling or counter-advertising a product. It's goal is really social norm change. The media campaign was created to emphasize and support what was being taught or being provided as services to young people in their communities.

A call to take specific action for young people (such as, call this number and you can get educated to wait for sex) was not a possibility, because we just didn't have enough local programs to provide those educational opportunities.

The entire ENABL program was funded at $5 million a year for each of three fiscal years. This provides support to 28 provider agencies throughout the state which serve about 100,000 youth each year, training of leaders, training of volunteers to expand the campaign without financial backing from the state, and administration, research and evaluation. On average, ENABL spends approximately $1 million a year in the media and public relations.

It is a media and public relations campaign because we chose from the beginning to extend the power and value of the media opportunities by using public relations support. Let me use an example. When we have a message on television, an ad for an automobile says, "Airbags in this vehicle make it a better car to purchase," this is use of a positive message -- safety -- as a tool to get the consumer to be attracted to purchasing the automobile. While this has a certain level of positive impact, it also engenders a certain level of denial. Everyone knows the vehicle manufacturer wants to sell cars and they are using safety features as their trick to convince people to buy cars. The audience in effect discounts the message including the value of airbags. If on the other hand on the news, we see a terrible accident, ten cars piled up, all of them with airbags and everybody is safe, we tend more to believe airbags are a valuable thing. Subsequently viewing the automobile ad, the safety feature of airbags is perceived to be

more valuable. Public relations activities help get messages in the news which tends to validate the message.

For this company it was valuable to add the public relations aspect which includes regular news coverage, public information shows, stories in print in newspaper and magazines, discussions from validated sources. It has been suggested in marketing that a validating source or a third party endorsement for a product is worth three to seven times as much as a straight ad. The news story may have more value than the printed ad. But the prepared ad is the way to be sure that the message is presented exactly as intended. The prepared, purchased media is much more controlable than the endorsement or news story.

Public relations and free media work together with commercial media. OFP has spent considerable time and effort encouraging public relations support of the program. Public relations activities have been very valuable to help leverage the limited media funds available for the campaign. The tobacco industry probably spends more per day in California to sell cigarettes than the ENABL program spends per year to encourage young people to postpone sexual activity.

The local ENABL programs are like a microcosm of the overall ENABL program. They also reach out to their local media. They also talk to the press. They have youth participate in programs like poster contests. They do a lot of the same things at the local level that OFP does statewide. OFP provided them with some tools: a program name and a label that they could use as a consistent identifier; public service announcements that they could provide for local media to use; and training and support for dealing with local news media. So a certain part of the media and public relations program was designed to assist the local 28 projects who are actually face to face with their community in implementing the core of the whole ENABL program -- a social change program.

Evaluation is important as a part of a media program. What works, what doesn't work? The goal of the ENABL media evaluation was to provide information for improvement of the program. This is also what commercial product marketing and business do all the time. The process is: plan, implement the plan, check to see if the plan worked, adjust the plan, do some more planning, implement the adjusted plan, etc. However, it is limited research. Not everything can be measured and accounted for. We can't isolate factors to say this ad turned these heads this much.

There is no way to precisely measure the impact of a single media effort. We don't know all the factors. We can attribute, but we can't measure absolutely, while there is a relationship between the cost of media and the outcome but it is not entirely predictable.

For instance, a major American manufacturing company has recently produced just one five minute ad at a cost of $500,000 before air time. Advertisers paid a million dollars for 30 seconds of air time on the Super Bowl. Are they going to get an exact return? Do they know what they will get for a return on investment? Can business be sure which product sales are

due to a specific ad? No, they can only estimate. This is true also with ENABL. We can attempt to indicate the value of what we had done, but we cannot be precise.

The ENABL media evaluation did measure some things. We did establish a baseline using two communities in California, Sacramento and Santa Monica, where we found groups of youth who were similar in income, ethnic mix and so forth. We attempted to measure if there was a difference in response where the media exposure was more intense versus where it was not. Los Angeles is the most expensive media market, and Sacramento is a lot less expensive. We were able to put more intensive exposure into the Sacramento media market than into Santa Monica. We surveyed youth perceptions, attitudes, beliefs, and self-reported behaviors, before we did any advertising, and once after each round of advertising. We wanted to see whether or not the message was being heard, if it was understood and if the frequency of exposure made a difference in audience response. Our paid advertising ran at most about four weeks in a fiscal year, which is a short run compared to most product advertising.

The media project set a goal of developing a 50-percent recall, which in the advertising industry is a very high recall -- so high that marketing firms told us it was an unreasonable goal.

The net result was near 80-percent recall among the youth audiences that were surveyed after the campaign. Changes in attitudes etc. were shown to be greater in a positive direction in the market with the more intensive exposure. This was an outstanding result. Additionally, in the recent focus group testing of new creative material, we interviewed approximately 60 young teenagers, 12 to 14, in northern and Southern California. We looked at the groups' responses to the existing materials, now three years old and have run probably only 12 to 16 weeks since the spring of 1992 (not very much time spread over that many years). Youth in these focus groups said they had seen and knew the commercials. They knew the words and quoted the lines.

Youth do register the messages. One of the things the kids had told us was, "We do see, We do hear, We do remember." They say that also about what parents tell them; they say that about what teachers tell them. These are influencers, and kids are listening. They remember what they see and hear. That is one of the reasons we need to develop new materials. We have to have something fresh so that audiences are not bored.

As with the Maryland campaign, the ENABL campaign was "commerically" produced. High quality production was needed to teach kids who are getting Sesame Street when they are two years old, and MTV today. A low budget, mimeographed public health message or black and white PSAs does not compete in today's market to gain young people's attention.

We learned several things which I think are important as we look at teenage pregnancy prevention and use of media as a vehicle. We learned through our focus groups and the follow-up surveys that young people don't want to be "told" what to do or how to behave and what's right. But they need to hear and they want to hear and they want to be comforted by hearing it without being "told." Of course the challenge is to figure out how to tell them to

behave without “telling them.” The other thing is that they really don’t want anyone to be blamed. They do not want someone to be the victim and they don’t want to be blamed. They want models to show them how to act. They want to be reassured that they are okay. Peer support is very important to the 12 to 14 age group. We listened very closely as they told us of wanting to be reassured. That’s why the messages of the ENABL campaign media are supportive. The campaign does not direct youth to a clinic. It is not telling them how to put on a condom. It’s being supportive to young people’s good values. The ads model saying “no,” young girls say things like, "I’m too young." "I already feel a lot of pressure." "You don’t have to have sex to have a special relationship." And the scene kids really identify with or seem to repeat the most often is one where a young woman’s full face is on the screen and she says, “What kind of NO don’t you understand?” That’s what youth wanted to know. It is OK to say no. They want to hear and see what it is they can do to live well.

We did take another tact in developing materials that were focused for adults. We used print ever so slightly, but as a call for attention from the adult public. The advertising industry and particularly newspapers have claimed that we didn’t do it enough. We ran only a couple of ads each year in the Sunday papers. Kids were our primary target. Kids are not heavy newspaper readers. The cost to run a print ad that appeals to the newspaper reading public does not seem to be the best use of limited funding. We are working now to maximize use of free print space.

We did strive to develop culturally sensitive material. The English spots that aimed for youth are multiculturally tested. The kids told us repeatedly they were acceptable. Youth are not apparently as concerned as adults about ethnicity or race of message givers in the media. However, we did also develop specific broadcast and print materials for a variety of cultural and language groups.

We used different ethnic marketing firms, as the state tobacco campaign has, for specific projects. This resulted in different thematic approaches. Instead of talking to teenagers about sexuality and pregnancy, subjects that seem to be talked about quietly and very little by parents in many cultures, ENABL promoted parent child communication. The ads really support the family taking a role in guiding their children. For instance, we looked at the Spanish language media that was affordable and effective. In Spanish language broadcasts, the highest audience is not teenagers, it is adults. So that was the reason the Spanish language piece was targeted to adults. We added some companion vehicles like the development of public service announcements to extend the impact potential. TV PSAs were aimed at parents. PSAs are more frequently aired during hours when more adults than children are watching TV. Many local stations were kind enough to run the PSAs surrounding the evening news.

We do feel strongly that if you develop the media tools that are of good quality and designed in the style of current commercial marketing, we can get further. We can get the local television and radio and various mediums to support the use of them. When broadcasters see good quality material, they are more willing to use it. Television stations, for instance, have drawers and boxes of public services announcements. Usually the PSAs that are the most

interesting and of high quality are the only ones to be aired. So we think that it is very important to continue to develop material that is very consistent with the quality and style of the advertising and programming that is on air. It costs more, but it is worth it because the impact is greater.

The media and public relations component of the Education Now And Babies Later campaign has not alone changed the world, but it seems to have contributed positively to changing youth perceptions supporting the value and viability of postponing initiation of sexual activity.

1995 CAFIS TEENAGE PREGNANCY PREVENTION POLICY ROUNDTABLE SERIES

Policy Roundtable #3: School- and Community-Based Teenage Pregnancy Prevention Strategies

THURSDAY, JULY 13, 1995, 8:45 A.M. - 12:00 P.M.

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:10 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:10 - 9:30 A.M. ***PRESENTATION #1:***

Karin Coyle, Ph.D., Associate Director of Research, ETR Associates. Dr. Coyle will discuss the evaluative work she and co-researcher Doug Kirby have done regarding school-based curriculum.

9:30 - 9:50 A.M. ***PRESENTATION #2:***

Charles "Cal" Crutchfield, M.S., Director of Prevention Programs, Boys & Girls Club of America. Mr. Crutchfield will discuss the Smart Moves Program, a community-based life options program provided in local Boys & Girls Clubs throughout the country.

9:50 - 10:10 A.M. ***PRESENTATION #3:***

Suzane Henderson, State Coordinator, Teen Outreach Program. Ms. Henderson will describe TOP and its effectiveness as a community-based teenage pregnancy prevention model.

10:10 - 10:30 A.M. ***PRESENTATION #4:***

Vandana Kohli, Ph.D., Assistant Professor, Sociology/Anthropology Departments, California State University, Bakersfield. Dr. Kohli will discuss the results of her recent survey of school-based teen pregnancy prevention activities.

10:30 - 10:40 A.M. ***BREAK***

10:40 - 11:10 A.M. ***STATE PRESENTERS/DISCUSSANTS***

Gail Maurer, Healthy Kids, Healthy California, California Department of Education
Janet Wetta, M.P.H., Office of Family Planning, State Department of Health Services
Arlene Roberton, Children, Youth, Families and Communities Division, State Department of Alcohol and Drug Programs

11:10 - 12:00 P.M. ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

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POLICY ROUNDTABLE #3

SCHOOL- AND COMMUNITY-BASED TEENAGE PREGNANCY PREVENTION STRATEGIES

Key Elements of a Successful School-Based Teenage Pregnancy Prevention Curriculum, ETR Associates, Karin Coyle, Ph.D.

Dr. Karin Coyle is the Associate Director of Research at ETR Associates. She is the Co-Principal Investigator for a five year federally-funded HIV, STD, and pregnancy prevention project for high school youth, and for a new five year federally-funded HIV and STD prevention program for middle school youth. Dr. Coyle will discuss the key elements of a successful school-based teenage pregnancy prevention curriculum.

I would like to start by thanking you for the opportunity to present today. This group is clearly in a position to make a difference for teenagers in your state. It is really satisfying to be living in a state that is interested in the research and looking at effective programs in how it makes policy.

I work at ETR Associates with Doug Kirby. He has done a lot of work in this field and my comments reflect some of the work I have done myself or with Dr. Kirby. We are interested in distilling the research completed to date on effective programs and have started looking at what characteristics are common across those programs. My comments stem from a synthesis of resources and not a new study.

The need for community and school programs is very clear. There are more than a million teenagers becoming pregnant each year in the United States and the majority of those are unintended pregnancies. One-fifth of the AIDS cases have occurred among individuals in their 20's and many were infected as teenagers. One in four infections occurred in people age 22 or under. STD is yet another problem. Three million teens acquire an STD each year. One in four contract an STD by the age of 21. School based approaches are part of the solution to addressing pregnancy, HIV, and STD.

People have looked to schools for very good reasons. Almost all youth are in school at some point. Youth are in school before they become sexually active. Schools are well-designed to educate youth, particularly those youth who are in the system and who are at high risk, and schools can either refer those youths for services or provide services for their youth on campus.

At the same time, however, the schools are being asked to do increasingly more. They are facing a lot of pressures in preparing youths for their futures. Resources are tight, class time is tight, staff are overburdened. Sounds kind of familiar, doesn't it? And all the competing programs pull at time devoted to issues such as pregnancy prevention. Despite the pressure, however, most of the schools have implemented AIDS and sex education programs. Over 93 percent of schools implement these kinds of education programs. Also, a lot of community agencies are now offering prevention services for youth.

When you look at the programs that have occurred in schools thus far, there is good news and there is bad news. The good news is that we've got data to show that those programs do not hasten the onset of intercourse and do not increase the frequency of sexual intercourse. The bad news, however, is that a lot of those programs are ineffective. They haven't changed behavior. Some of them have increased knowledge; others have changed attitudes. We don't measure skill very well, so we don't really know skill impact in this area. But by and large, they have been ineffective at changing risk behavior, which is really what we are after if we want to reduce the one million pregnancies occurring a year.

It's not all bad news. There are some effective programs and today we will be looking at some of the characteristics of those programs. The second page of your handout lists some selected programs with positive behavioral effects. (See handouts following Dr. Coyle's presentation.) These are not all of the programs, and you are going to be hearing about a couple others that aren't on this list, the TOP and SMART Moves programs. When you look at this list of programs, it's important to recognize that they have different goals and they have different outcomes. The evaluations of these programs are mostly strong, but there are some weaknesses in the evaluation. Just to give you a synopsis, the in-school program Reducing the Risk was a high school program that had an impact on initiation of sexual intercourse. It was able to delay initiation. That finding was only detected at the 18-month follow-up; it was not evident at the 6-month follow-up, giving us some information that the incidence of sexual activity among youth wasn't great enough at the six-month follow-up for us to detect change. Once the youth started initiating sex, we were able to see that change at 18 months. So that 18-month follow-up was an important data point. The program also impacted contraceptive use, but only among those youth who initiated sex after participating in the program. So it had no impact on those youth who were already sexually active, and that's a sizable portion of the youth that we are not impacting in that particular program.

Get Real About AIDS did not have an impact on initiation or abstinence, but it did have an impact on condom use. It also reduced the number of partners. AIDS Prevention for Adolescents impacted condom use and increased consistent condom use. It impacted monogamous relationships and reduced sex with high risk partners.

Be Proud, Be Responsible, an after school program, targeted African American males. That program really targeted using protection. That was its main focus, and it was successful in increasing the frequency of condom use in that population. It also was successful in reducing the number of partners. Behavioral Skills Training is a brand-new program. The data just came out this month in a published journal article. It had a real nice tight evaluation, and showed very strong, positive effects. It was aimed at African American youth in Mississippi. They found a delay in initiation, a reduction in number of partners, increased frequency of condom-protected sex and in the percent of acts that were protected by condoms.

The Teen Incentive Model also showed a decrease in frequency and increased contraceptive use. It was not effective on abstinence. A program for runaway youth is one of the only evaluated programs published in the literature that focuses on that population. They found

positive effects for condom use and avoiding high risk situations, but it had no impact on abstinence.

So clearly when you look across the studies, we don't have a magic bullet. We don't have one solution. We don't have one program that is going to do it all. But we are starting to amass a set of programs that are showing some positive behavioral changes.

The first characteristic is that the effective programs focus narrowly on reducing sexual risk-taking behaviors. As I just mentioned, those programs listed previously focused very narrowly in reducing unprotected sex, either by choosing not to have sex or by using protection, or some of them, such as Postponing Sexual Involvement (PSI), focused on delaying intercourse. There was a very narrow behavioral emphasis in the program, as opposed to some programs that were broader in scope and more general.

Secondly, the effective programs are based upon social learning theories. Essentially, the social learning theories provide a framework around which we can build these programs. They identify the factors that are linked to behavior change. What that allows us to do is develop interventions that address these factors and target the factors that are changeable. Some of the factors include functional knowledge, motivation, and skill. Other factors are belief that the skill we're teaching really will have an impact -- that using a condom really will reduce HIV, or using a condom and pill really will prevent pregnancy and STDs.

Another factor that was very important is self-efficacy or the belief that the youth can actually carry out the behavior -- that they can use a condom every time consistently and correctly. The programs that don't have an underlying theory often tend to be a collection of activities, and the activities could be really fun for the kids but they are not focused on the behavior change. So that's the importance of the underlying theory.

Third, effective programs provide functional information and use a variety of teaching methods to personalize the information. Functional is really the operative word. We often overload on knowledge, and many programs emphasize knowledge far too much. Think about an HIV prevention program, for example. Knowing the structure of the virus might be interesting and they often teach that in science, but it doesn't have any impact on preventing HIV. If you know the structure, it doesn't mean that you know what to do to avoid it. But information that deals with or addresses how the virus is transmitted or how you can prevent it, that's functional information and that will provide youth or individuals with something on which to act. So functional is important, and a limited amount of information. Most of the effective programs do not focus heavily on knowledge.

The programs use real interactive methods rather than didactic approaches. This not only increases the student's involvement in the learning, but also helps personalize the learning.

I want to digress a little bit and give you an example from one of the curricula. I want you to all imagine that you are teenagers again and that we are in a class discussing pregnancy risk and how we can affect our risk. Currently, based on national statistics, teenagers who have

sex and don't use protection have a 90 percent chance of becoming pregnant within a year. As an aside, teenagers wait an average of eleven months after initiating sex before they use contraception.

So what I want you to do is pick a number between one and six and I want you to write it down. That number represents the probability that you will experience pregnancy in any given month. Now I also want you to imagine not only that you are teenagers, but that you're having unprotected sex every month. I know that is not true, because some of us are working so hard that we can't even -- we are so overwhelmed that there's not even a chance in engaging in anything other than work, and then some of us may be using protection and some of us may be choosing not to have sex at all. But for the purpose of this activity imagine you are having unprotected sex every month. I'm going to roll this die. Those of you with the number four, if you will stand up and remain standing. You had unprotected sex this month and you are pregnant. Stay standing. Those with number five join the group. There's a few males and we know you can't get pregnant unfortunately. You do contribute to pregnancy, so you are all pregnant. Number ones standup. Have a seat.

Now we will redo this activity and take a look at how we can take measures to reduce our risks for pregnancy. And we are going to look at what happens when we choose not to have sex or we choose to use protection. So I want you to refer back to your number and I'll draw these slips. Number fives will you stand up again? Okay. This time it says you and your partner did not become pregnant because you both decided you weren't ready for sex, so you can sit down. Number fours stand up, please. You and your partner didn't become pregnant because you or your partner used the pill correctly. You may sit down. Number five, stand up again. You're not off the hook. You're pregnant. You decided to have sex without protection.

So if you look at the number standing up now versus the number standing up previously, what happened? It went down. That gives you an example of the interactive approach. We could have drawn this out and done a lot more debriefing in the classroom. It is truncated for this purpose today. But it gives you a flavor of the interactive versus the real didactic approach, and that seems to be important in the more effective programs.

There are a lot of other activities that are used in these programs that are interactive. Many of you may have heard about activities where you go to the stores and look for condoms. We don't ask them to buy condoms, but they look for the placement of condoms. Those kinds of activities, and activities that engage kids in conversations with their parents, are the interactive activities that seem to be common in the effective programs.

Effective programs also include activities that address social and/or media influences on sexual behavior. One of the more common approaches is looking at lines, pressure lines, that kids often hear or experience, and then coming up with retorts to those lines. "If you love me, you will do this." "If everybody else has done it, why can't we?" And the kids can generate those pretty easily and they then practice some retorts to those so that when they are in that

situation, the hope is that they've gone through it and they've experienced it in a controlled setting and maybe it will come to them and they can get out of pressure situations.

The other aspect of this characteristic is a lot of kids who end up having sex, and it's about two-thirds of the kids, say they didn't plan on having sex, it just happened. So some of these curricula look at situations -- I use the terms sex possible situations. They can identify either events or settings where things are likely to get out of control or beyond where they want them to get. Either they are home alone, no parents for a couple hours, they are at a makeout party, or those kinds of things where they know things are likely to heat up. And if they identify those ahead of time and identify some strategies to get out of those situations or avoid those situations completely, that seems to be helpful. So those things are addressed. Then media pressure is addressed in some but not all of the effective programs. That is usually analyzing the media and sometimes developing positive media messages that promote responsible behavior such as choosing not to have sex or using protection when they do have sex.

Another characteristic of effective programs is they reinforce clear and appropriate values and norms. This is one of the most important factors, it appears at this point, that distinguishes the effective and ineffective programs. In the past, general decision-making approaches would list a bunch of steps and not really promote a particular norm or value, such as delay or choosing not to have sex or using protection. They just laid all the steps out and let the youths decide what was best for them. But the current programs are really targeting a value or norm and trying to foster that norm within the classroom environment.

Values and norms need to be age and experience appropriate. When you look at that list of programs before, Postponing Sexual Involvement, for example, which targets middle school youth, the value or the norms there is delay and that is quite appropriate. Most middle school youth are not active. We want them to delay becoming sexually active. Using that same message in an inner-city high school setting is not likely to have the same impact. The norm there might be use protection. The abstinence or choose not to have sex message is generally there, but the emphasis might be on use protection because such a large portion of those youth are already engaged in sexual activity.

Another important factor is that the norm or value is reinforced throughout the program. It is not just mentioned once. It forms the basis of the program so it gets reinforced in every lesson, in every activity that the youth do. It forms the basis for what kind of knowledge gets included, what kinds of skills are addressed and what kind of activities are implemented.

A sixth characteristic of these effective programs is that they provide modeling and practice skills. That's an underlying tenant of the social learning theory. Usually the programs will introduce the skill, they will model the skills so the youth can see the skill performed correctly. Then youth will have an opportunity to practice that skill and get corrective feedback. Typically they will practice it in more difficult situations over time which lends to their belief that they can indeed do this skill. It will start with the more scripted and move to more unscripted, or start in easier situations and move to more difficult situations over time. This is

one area where the effective curricula differ the most. The Postponing Sexual Involvement curriculum has relatively little skill practice. Reducing the Risk, on the other hand has extensive skill practice. We just don't have the research at this point to say "you need X hours of skill, X hours of norm and this component to be effective." We just haven't looked at that level. The substance abuse prevention field is a little bit further along than we are in looking at that, but we don't have hard data on that issue.

Another characteristic of the effective programs is they provide training for the implementor and that's pretty important. Preparing those individuals who actually implement the program, typically involves providing background information on the program and allowing the implementor to see the programs modeled and have an opportunity to practice the lessons.

Lastly, effective programs consist of at least ten hours, or they're presented in a small group format, a group of ten to twelve kids with one leader, so that the time is really maximized. Postponing Sexual Involvement (PSI), when it was evaluated, was ten hours. PSI in its current use has been shortened to five hours, which has not been evaluated. Be Proud, Be Responsible was a relatively short program; however, the kids were grouped in groups of ten to twelve with one leader. So that appears to be a commonality in effective curricula.

We've got some research to support that longer programs are more effective, but some of the data have limitations. It has been done with volunteer groups, and those kids are likely to be different than walking into a school setting where some or all of the kids don't want to be there. We're just kind of looking at the number of hours at this point.

Some conclusions: It is clear that educational approaches in the schools can reduce unprotected sex and not all curricula are effective enough. Education alone is not enough. We have research to support that generic skills are not enough. Effective curricula seem to have several common characteristics -- a clear and consistent message may be among the most important. There is also other research to show, the importance of an adult role model -- and that's what is operative in the Teenage Outreach Program and some of these other programs -- one person the kids like, either a parent or another adult.

We clearly don't have complete solutions at this point, in terms of classroom curricula. No single curriculum is likely to have the impact to reduce risk-taking behavior to a level that we'll all be comfortable with. Given the rate of pregnancy, STD and HIV, we need to look at comprehensive efforts that complement and reinforce each other. Youths function in a lot of different environments -- community, home, peer -- and ideally we will look at programs that complement each other and reinforce the same messages in all of the environments.

I want to close by noting again that my comments are drawn from a synthesis of research. There are several programs that we've looked at recently that are great programs and they appear to include a lot of these characteristics, but they had no behavioral effect. So we're on our way, but we're not there yet. We still have a lot to learn.

Smart Moves Program, Boys and Girls Club of America, Charles "Cal" Crutchfield, M.S.

Mr. Charles "Cal" Crutchfield is the Director of Prevention Programs, Boys & Girls Clubs of America, based in Atlanta, Georgia. In that capacity, Mr. Crutchfield directs development and revisions in alcohol, drug abuse, and pregnancy prevention programs and projects. Cal will discuss Smart Moves, a Boys & Girls Club program that addresses a number of risk behaviors, including teenage pregnancy prevention.

Boys and Girls Clubs of America is set in a tradition of serving youth. In 1860 the first Boys Clubs started in Hartford, Connecticut. There was a national organization that was created in 1906 that was called the Federated Boys Club and later the Boys Clubs of America. That national organization was created by 53 local clubs that were in existence at that time to promote new boys clubs throughout the country as well as provide services and programs for the existing clubs.

In recent years we've experienced dramatic growth. Since 1987, just eight years ago, we've gotten 800 new clubs. We now serve 1675 facilities throughout the country and serve 2.21 million children. The Chronicle of Philanthropy recently ranked the Boys and Girls Clubs of America as number 12 among all nonprofit organizations in its efficient use of financial resources. Money magazine also ranked the Boys and Girls Clubs among the top 15 for its cost effective use of donor dollars. Fortune magazine surveyed the best-run charities in America, and Boys and Girls Clubs was the only youth oriented organization on that list. As a result we are endowed more than any other youth services agency by outside agencies and corporations.

Our American youth face many difficult challenges today, but with our 135 year history and tradition, we continue to offer proven solutions to young people that work. We've got clubs that have been providing services for girls and boys throughout the country with daily guidance oriented, character development programs, firmly establishing the fact that we are the positive place for kids. Each of our individual clubs are independent. They are each nonprofit organizations that affiliate with the national organization. There are many clubs out there that aren't affiliated with us, and we don't count them on that 1675 roster.

The Air Force has just decided they will turn all of their youth centers on air force bases into Boys and Girls Clubs. This will enable them to get the training and the resource development that is needed to become youth development professionals. They will become part of the national organization as well. I'm told that the other services, the Army, Marines and Navy, are also moving in this direction. So you can look for a big increase in the number of clubs out there when the military-base clubs get going.

Each club is professionally staffed and fully equipped. They offer daily programs promoting health, social and educational, vocational and character development for youth. I think that's one of the reasons why we are successful in our programming. SMART Moves as a program is a very good program, and it has been found to be successful as an individual program. But

it's also, I think, an indication that all of the things we are doing really make the program work. It's not just the program itself.

We're having a positive impact on building lives of children in their own communities. We go into places where other programs won't go in. We serve disadvantaged young people. Each of our clubs is managed by a full-time executive director and serves quite a number of kids. There are 6,200 trained professional youth workers and 16,600 part-time staff members of our clubs. There are 77,000 board and program volunteers, and we have an operational budget with all the clubs of over $300 million. The estimated replacement value of all the Boys and Girls Clubs buildings and capital throughout this country is some $866 million.

Where are the clubs? Seventy-one percent of our club members live in urban inner-city areas. Fifty-three percent come from single parent families. Fifty-one percent come from families with three or more children. Fifty-four percent come from minority families. Forty-two percent come from families with annual incomes below $22,000. Sixty-three percent of the youth are male and thirty-seven percent of the youth are female.

In 1990, we changed the name to Boys and Girls Clubs in recognition that we had been serving girls all along anyway. We negotiated with Girls Clubs of America and decided to change our name to Boys and Girls Clubs of America.

There's been quite a number of people that are graduates or alumni from our program. I want to read you a few of these names of people who have come out of the Boys or Girls Clubs or at least credit the Boys and Girls Clubs for their own development. C.J. "Pete" Silas, who is recently the retired chairman of the board of Boys and Girls Clubs, and he is also retired chairman and CEO of Phillips Petroleum. John Smith, president and CEO of General Motors Company. Bill Clinton. Jack Kemp. Dan Rather. Bernard Shaw. George Burns. Bill Cosby. Danny DeVito. Walter Mathau. Martin Sheen. Denzel Washington, I hope you've seen some of the ads he has been doing lately for us. Robin Williams. Bob Greisey. Gayle Sayers. Bart Star. Mark McGuire. Magic Johnson. Michael Jordan. Shaquille O'Neill. James Worthy. Jose Canseco. Joe D'Amagio. Lou Panella. Brooks Robinson. George Foreman. Evander Holyfield. Sugar Ray Leonard. Olympians Jackie Joyner-Kersey, Greg Louganis, Edwin Moses, and Joann Benoit Samuelson. These are all people that we hold up as examples and role models to kids that are in our clubs.

SMART Moves is part of a total comprehensive program. SMART Moves, in and of itself, is very comprehensive and I will go over those details later, but there are also other things that go on in the clubs that are very important. One is the National Youth of the Year Program. Each club produces a Youth of the Year for the Club. Those members then enter a statewide contest, then a regional contest, and finally a national contest of the Youth of the Year for the Boys and Girls Clubs of America. That person gets to go to the White House and meet the President and do all kinds of things. It has targeted outreach programs which identify and recruit delinquent youth and youth at risk of delinquency. It's ongoing at all the clubs. There is "keystoning" which focuses on leadership development for the older teens. There is

educational enhancement programs, cultural enrichment programs, career exploration and job search programs, environmental awareness and sectional tournaments.

Studies show that Boys and Girls Clubs work. Steven Schinke, Ph.D., at Columbia University, found that where Boys and Girls Clubs were present in public housing units -- and we are in 270 public housing units across this country today -- there was 25 percent less presence of crack cocaine in those units, 22 percent less overall drug activity, and a 13 percent reduction in juvenile crime.

We also have a mentoring program in which we ask older youth to bring other younger peers with them so that the younger peers become the new leaders of SMART Moves as older teenagers. We sometimes have a more difficult time reaching the older teenagers. Taco Bell just awarded us a $15 million five-year grant to enhance the teenage programming at Boys and Girls Clubs. That will support 100 new TEENSupreme centers throughout the country, and expand the current teen centers. Teenagers will become involved in that process, and have a say in what each TEENSupreme center looks like.

Now obviously many of the studies in the past have dealt with the substance abuse issue because SMART Moves is an alcohol, tobacco, other drugs, and pregnancy prevention program. It is one of the few programs that I know of that encompasses all of those risk factors. However, we are changing the program, focusing on resiliency and the strengths kids have and bring to the program and to the clubs themselves. It is a positive place, again, for young people. Where youth attend the Boys and Girls Clubs in after school programs, there have been lower percentages of academic failure and fewer behavioral problems in school.

There are basically two systems: the social system, which we think are the Boys and Girls Clubs; and the family support system. (See handouts following Mr. Crutchfield's presentation.) What has to happen in the social support system and the family support system is they have to create high expectations for youth. Through these high expectations these youths then have the opportunity to learn skills, opportunity to assume responsibility, and opportunity to participate in community and public affairs successfully. This has to then be reinforced by the family and by the social support system. All too often, for the kids that we see in the high risk areas, we also become the family support system. When the family may not be there, or the family may not provide the reinforcement that is necessary, the social system, Boys and Girls Club, is going to able to provide that for our kids.

SMART Moves is a very comprehensive program made up of:

- SMART Kids, which is a program for six to nine year olds;
- Start Smart for ten to twelve year olds;
- Stay Smart for thirteen to fifteen year olds;
- Keep Smart for parents;
- Act Smart, is a new curriculum that is coming out next month for HIV/AIDS education that is broken down into curricula for three age groups (6-9, 10-12, 13-17);

- SMART Ideas is our community-based community awareness activities which provides the same messages to adults that the kids are getting;
- Be Smart is inservice training for the staff and does involve the volunteers that are involved in the SMART Moves program; and
- SMART Operators teaches management and club staff and board members how to get involved and support the program.

We train prevention teams. These prevention teams are made up of staff persons and community persons and at least two peer leaders. The ideal team is made up of several small prevention teams; one prevention team covering the ten to twelve year olds, one covering six to nine year olds, and one covering thirteen to seventeen year olds. You have six adults, three of whom are staff members at Boys and Girls Clubs and three of whom are community members or parents of young people, and then six young people. This insures the young people play a major role in the development and implementation of their own prevention programming.

There are four messages. The core messages of SMART Moves are:

- Say no to alcohol use.
- Say no to tobacco use.
- Say no to other drugs use.
- Say no to sexual involvement.

In many ways the refusal skill model is certainly part of the SMART Moves program. However, it is not the most important part. We know from research that even though they practice saying no in role playing settings, that they still are going to be concerned about their friends. And their friends are the people that offer and solicit sexual behavior as well as drugs and alcohol.

The SMART Moves program was originally developed in 1988. It is based on work in 1985, at the University of Southern California. This also is the basis of the DARE program in Southern California. Gil Botvin's "Life Skills" program incorporated the work on life skills efforts from Columbia University. Then we waited for the research and found out what was working in the program, and adapted it to the Boys and Girls Clubs. That's how we came up with an effective program.

We only allow role playing between the participants and the youth leaders. The youth leaders are the ones that play the negative roles or the coercive roles, and the participants in the program play only the positive roles. That is one change we have made recently in the role playing techniques.

SMART Moves is comprehensive and based on a set of principals. It involves youth in a strategic way, even more now than in the past. In the past, the curriculum basically said for the adults who are running the program to get the youth to assist them. Now, youth run the program and the adults assist the youth, through teamwork and through program skills

development. They usually teach in pairs, so they help each other out and become role models.

SMART Moves is primarily famous for its alcohol, tobacco and drug prevention, but it does cover sexual involvement. So I went back through some of the research and I found out what was going on. Basically there were some evaluations that were done. And there was a sex attitude scale which asked questions like, Is it all right for teenagers my age to have sex? Girls who go all the way are more popular with boys? Having sex means you're more grown up? Boys who go all the way are more popular with girls? Being sexually active shows you're cool? Boys should have sex to keep their girlfriends interested in them? If a person my age hasn't had sex, is there something wrong with them? This study found that people who participated in SMART Moves held significantly less favorable attitudes over control groups. The same study also found that people who participated in SMART Moves with a booster program were about equal to those who were in the regular SMART Moves program.

I reviewed the CDC's findings prepared by the group which Doug Kirby chaired. I found SMART Moves is grounded in social learning theory. We teach that actions have consequences, the young people teach each other that actions have consequences. They empower youth to change their behavior and get the results they want. Classes and lessons are age appropriate. Use of role playing where participants play only positive roles to discourage initiating sexual activity and, when appropriate, also describe how and when and where to use protection. They practice refusal skills which increases communication skills, one of the indicators that we know is positive for good prevention programs. If a program is good, communication skills among participants is going to increase. We also know that group cohesion increases. We have a lot of peer support and we have a lot of group cohesion and team building activities. It is part of a comprehensive prevention strategy. Parent involvement in education is included. Community-wide events and projects increase awareness of the whole community and it is part of a national media campaign. So all in all, all of these things add up to what I think makes SMART Moves a successful program.

Dr. David Satchen at the Center for Disease Control in Atlanta stated recently that "Young people must have a reason to believe that they can change the future for themselves and for others." Then it will be easier for all of us to deal with violence and substance abuse and teenage pregnancy. If we can't do that, then we are really lost. Many children come from multiproblem families. They accumulate liabilities even before they are born. But after birth, many children and families experience failure so often that they come to believe that they are meant to fail. They begin to comprehend that the future holds little possibility for them, and they convince themselves that they have little to lose by dropping out of school, using drugs, committing violent crimes, and having babies at a young age. We've got to turn that cycle around. Everyone in this room and everyone in this country is a stakeholder in the future of our children and in our own future. Everyone is accountable. This should be everyone's business.

California's Teen Outreach Program, Suzane Henderson

Ms. Suzane Henderson is currently the state coordinator of the Teen Outreach Program, sponsored by the Association of Junior Leagues International, Inc. She is working in California to develop the first state model for replication and institutionalization of this nationally recognized youth development program. Suzane will describe the Teen Outreach Program in California.

The Teen Outreach Program (TOP), sponsored by the Association of Junior Leagues International, has been one of the best kept secrets in the field of teen pregnancy prevention for a long time. I think people are surprised when they learn that Junior League is the sponsor of TOP. I want to dispel the myth that Junior Leagues are just ladies in pearls. The Junior League is an international organization of women committed to promoting voluntarism and improving communities through effective action and leadership of trained volunteers. Leagues have a long history of developing and supporting programs at the local and international levels.

Teen Outreach is one of the very few programs that has actually documented evidence of behavioral change. We now have ten years of data collected by Dr. Susan Phillilber of Philliber Research Associates. The data are demonstrating an 8 percent lower rate of course failure, an 18 percent lower rate of school suspension, a 33 percent lower rate of pregnancy, and a 60 percent lower rate of school dropouts. These are Teen Outreach students compared to students not enrolled in the program. The ten year data is based upon evaluation of approximately 5,000 TOP students and 5,000 control students.

The Teen Outreach Program was conceived by a teacher in St. Louis, in 1978. She was concerned about teenage girls dropping out and getting pregnant. In 1981, The Junior League, in collaboration with the Danforth Foundation, helped support a city-wide replication. Later, the Charles Stewart Mott Foundation and several other national funders provided support.

Since 1987, the Association of Junior Leagues has been responsible for the national replication of Teen Outreach with funding from the Charles Stewart Mott Foundation. Since then TOP has been implemented in up to 200 sites nationally. These were community sites in which Junior League volunteers worked with school districts to implement the program in 1-2 classrooms. As the data began to demonstrate the effectiveness of the program, the Association of Junior Leagues realized that the program should be provided to larger numbers of young people.

Consequently, in 1991, California was selected as the first state model for replication and institutionalization. The feeling being, of course, that if it works in California, it should probably work anywhere. At the same time, seven existing TOP sites outside of California were selected to develop community models for district-wide replication and institutionalization.

In California, I do want to acknowledge the Stuart Foundations encouragement and support for the initial development of the California model. We would also acknowledge the generous support of the California Wellness Foundation and the James Irvine Foundation for supporting out state management structure. Local programs have received funding from the Luke B. Hancock Foundation, the Weingart Foundation and the Sierra Health Foundation.

The mission of Teen Outreach is to allow youth to build self-esteem and critical thinking skills, life management skills, and the ability to set future goals. It promotes personal, social, and intellectual growth, as well as civic responsibility and preparation for the world of work. There are two components to Teen Outreach: weekly discussions using the TOP life skills curriculum and weekly participation in community service.

In the classroom component, a trained facilitator, it can be either a teacher or counselor, facilitates experiential exercises from the TOP life skills curriculum. By experiential we mean that students actively participate. For instance, if we were in the first day of a Teen Outreach class, there would be an exercise in which students are blindfolded and do a trust walk through the school. Most principals always know when it is the first month of Teen Outreach because there are lots of kids roaming around the school with blindfolds. In another exercise the teacher lines up students and taps each of them a certain number of times on the hand. If I were the teacher and this was the classroom, I'd tap Cal's hand one time and Karen's hand two times, and your's three and so on around the room. Then without speaking, all of you would be asked to order yourselves in the sequential order in which you were tapped. Students are required to work together to meet the task. The exercise also gives the teacher the opportunity to see who is going to take the lead, who is hanging back, and who thinks this is the dumbest thing they ever did. The exercise which occurs early on in the school year lets the students know that this particular hour during their school day is going to be a little more fun and quite different from most of the other classes. Teen Outreach also allows the classroom teacher to interact with the students in a new way. It is a teaching method supported by Goals 2000 in which the teacher is a coach.

Other units in the TOP curriculum include understanding yourself and goals-setting. There's a unit on celebrating diversity, not only cultural and ethnic diversity, but also diversity in terms of physical disabilities. Other units include exercises dealing with development of communication skills, making responsible decisions, and planning for the future and the world of work. Interestingly enough, of the eight units in the TOP curriculum, only two focus on sexuality education. One deals with physiological changes during adolescence and the other deals with understanding relationships, stressing abstinence. There are optional sections that deal with contraception, STDs and HIV infection. The curriculum itself represents a compilation of some of the best of existing and new life skills curricula. The curriculum has been compiled by Dr. Carol Hunter-Geboy.

The second component of TOP involves students in regular participation in community service projects. The second unit in the curriculum introduces this community service component. Students use murals to draw maps of their communities, including physical attributes as well as pictures depicting problems or issues of concern. We have seen pictures of little girls with

circles on their tummies representing teenage pregnancy, we've seen guns, we've seen needles, and police cars. Discussions about the murals lead to the development of the community service projects.

In the past, projects were set up and organized by Junior League members. Here in California where we are serving larger numbers of students, we usually have a paid coordinator from a local volunteer center or a community based organization. In some cases, districts have redirected existing school staff to serve as the coordinator. Service projects may be group or individual projects. We find middle school students prefer group projects where they might focus on reclaiming a local park, participating in graffiti removal, or organizing school recycling projects. Since high school students are more easily transported or have their own transportation, they are more likely to serve in individual placements in day care centers, hospitals, and senior citizens centers where they work one on one with individuals. The key to success is allowing students to participate in selecting their service projects.

Many service projects enhance existing academic curriculum through service learning. Service learning is also part of the Goals 2000 school reform agenda. After each project, students are required to participate in reflection exercises. These exercises include discussion, writing in journals or conducting related research. For instance, students who work with seniors might record oral histories of them and write biographies of the seniors for a U.S. history class. Students who participate in cross-age tutoring strengthen their own skills in language arts, math, science, or art, depending on the class they tutor. The service projects also provide students with career exploration and adult mentors.

There are currently seven Teen Outreach sites in California and plans for expansion are currently underway.

School-Based Family Life and Sex Education Programs in California, Vandana Kohli, Ph.D.

Dr. Vandana Kohli is currently employed as Assistant Professor in the Department of Sociology at California State University, Bakersfield. She teaches classes in demographic analysis, geographic information systems, and research methods. She has published a variety of articles on the demography of Asian Indians residing in the United States, the impact of birth order on educational attainment, and teenage pregnancy. Dr. Kohli will discuss the recently published report she co-authored with Dr. Kenneth Nyberg on school-based family life and sex education programs in California.

Our research was essentially a survey of the school districts in California. The research was funded by the Faculty Fellows Program, Center for California Studies located at California State University, Sacramento. I want to acknowledge and thank them for their contribution in helping facilitate this research.

The report has three major components: the first part contains an extensive literature review; the second part summarizes the research methodology and the qualitative and quantitative results of the survey of California school districts; part three contains policy suggestions based on our survey results. The policy implications are derived directly from the survey results and are not merely selected from the literature. Today, I would like to share with you two elements of the report: select survey findings; and policy suggestions. I hope the latter will demonstrate a lively discussion.

In designing and implementing a survey of the school districts in California, our goal was to construct a representative sample that was large enough to allow for the statistical manipulation of variables. A randomized fifty-percent sample was drawn by consulting the California Public School Directory which yielded a final sample of 508 school districts. We mailed out a questionnaire to all of the target school districts and followed it up with a postcard reminder one week later. Another questionnaire was mailed out to nonrespondents, followed by another postcard reminder a week later. If someone had not responded by then, we mailed a third and final questionnaire. By the third or fourth day, we started receiving phone calls from people around the state asking us questions, and expressing interest, and a lot of enthusiasm about the topic of our research. I think this expression of enthusiasm speaks very well of the kind of people we have working in our schools; that they take such a lot of interest in matters that are germane to their jobs and the future of our children. Our repeated mail outs and district officials' cooperation yielded a 54 percent response rate. We continue to receive completed questionnaires, however we have only analyzed the information that we had available as of the last week of May 1995.

In our sample, 226 or roughly 87 percent of all districts offered Family Life Education (FLE) in their schools. Further, 172 districts or nearly 77 percent required the schools in their district offer FLE. These data are summarized in Table 9. (See handouts following Dr. Kohli's presentation.) However, as is evident from Table 10, all those districts that do not offer FLE do so because their district does not require that FLE classes be offered. The same

table also indicates that nearly 22 percent of the districts in our sample offer FLE even though they are not required to offer FLE.

Further, even though so many school districts provided sex education programs, the data indicate that school districts, for the most part, do not maintain data related to AIDS prevention, incidence of teenage pregnancy, and/or venereal disease. Nearly 94 percent of all districts do not maintain data on AIDS; nearly 81 percent do not maintain data on student pregnancy rates, and nearly 97 percent do not maintain data on the incidence of venereal diseases among students. This information is clearly presented in Figure 3, and provides the basis for one of our policy recommendations: school districts should keep data on these important variables.

Respondents were also queried as to whether their FLE curriculum was offered along with their AIDS prevention program; did they have any special policy regulating the qualifications of FLE teachers; and were their FLE teachers trained in any particular subject area? Eighty-four percent said that they did offer the FLE curriculum along with AIDS prevention. Among all 236 districts for which data is available only 31 percent required that FLE teachers have specific qualifications whereas nearly 70 percent of all these districts did not have such a policy. Reflecting this lack of credential regulation, FLE teachers in 75 percent of the surveyed districts are not required to have particular subject matter competency. These results are presented in Table 6.

The preceding discussion should not imply that California school teachers are not qualified for their jobs; most school districts require that their teachers hold a teaching credential. The problem, according to the current survey, is that teachers who teach FLE are not trained in that particular subject area. The subject area training of various FLE teachers is presented in Table 7.

One of the recommendations that is forwarded in this report is that FLE teacher training be standardized so as to provide adequate teacher preparedness. Based on the survey results, we also recommend that the FLE curriculum be standardized for content, the grades at which it is taught, and total number of hours spent on teaching the curriculum. There is a lot of qualitative information presented in our surveys which indicate the need to implement prevention programs before the onset of "deviant" behavior. However, no matter how we coded the data, we found a tremendous inconsistency across our school districts regarding the grade at which the FLE curriculum was offered. The same was true of the number of hours of FLE instruction. Research findings seem to indicate that 10 hours of FLE instruction translates into effective prevention strategies. But, our survey revealed that California school districts offer 0 to 5 hours of FLE instruction. However, this information should be interpreted with caution since the data was not presented in a coherent manner. Standardization also has the additional advantage of protecting our teachers from accusations of arbitrariness and subjectivity. (See Tables 11 and 12.)

School districts also report that, contrary to popular assumptions, parents and community groups do not withdraw their children from FLE classes. They are, however, apt to pressure

the district office to modify the FLE curriculum. Yet, even in this instance, the pressure for modification comes from church groups and not from parents. (See Tables 13 and 14.)

The final, and probably most important, concern of this study was to investigate how much time was actually spent on teaching some topics in FLE classes and what rank of importance was placed by practitioners on the ideal amount of time that should be spent on teaching these same topics. The topics that we included in our survey emerged from a review of the literature on the FLE curriculum and its implementation. The literature identified the following topics: AIDS prevention; VD prevention; responsible sexual behavior; values concerning sexuality; improving family interactions; strengthening the individual; improving self-esteem; improving academic performance; physical development; human reproduction; using contraceptives; consequences of early sexuality; consequences of pregnancy; dating; peer pressure; awareness of the opposite sex; enhance decision making; and alternative life styles. We asked respondents to rank on a scale of 1 to 3 the actual and ideal amount of time they thought is, and should be, spent on teaching these topics for four different grade levels; K through 3; 4 through 6; 7 and 8; and 9 through 12. Table 17 summarizes the results of this line of inquiry, and reveals that average scores for ideal amount of time that should be spent on teaching particular topics always exceeded average amount of time that is actually spent on teaching the same topics. The only exception was teaching children in grades K through 3 about dating.

Regardless of grade levels, respondents ranked improving self-esteem as the most time absorbing topic closely followed by peer pressure but only in the two higher grade levels. Very little time was actually devoted to the teaching of contraceptive use except in the 9-12 grades and, in all grades, teachers spent very little time addressing alternative life styles.

Importantly, there was a consistent difference in the actual and ideal amount of time respondents identified as being devoted to teaching elements of the FLE curriculum for different grade levels. We have presented the information for different grade levels in the following four figures, Figures 5 through 8. Figure 5 shows that, for the K through 3 grades, the greatest discrepancy between actual and ideal amount of time exists in teaching students how to enhance decision making, cope with peer pressure, and improve family interactions. Again, as we summarized in the preceding discussion, the greatest amount of actual time was spent on improving young people's self-esteem.

The results for grades 4 through 6 are presented in Figure 6. As in grades K through 3, respondents would like to spend more time teaching enhanced decision making, coping with peer pressure, improving family interactions but, in addition, in these grades respondents report a significant discrepancy between the actual amount of time that is spent teaching students about dating, and the consequences of pregnancy and early sexuality. As in all other grades, the greatest amount of actual time is spent on improving student's self-esteem.

Figure 7 presents the results for grade 7 and 8. Here, in addition to the topics we have previously mentioned, respondents identify the greatest discrepancy between actual and ideal amount of time devoted to teaching students about contraceptive use, sexual values and

responsible sexual behavior, and VD and AIDS prevention. Again the greatest amount of actual time is shared in teaching about self-esteem and coping with peer pressure, but in grades 7 and 8 respondents spend more time also teaching about strengthening the individual.

In grades 9 through 12, there is a differential in the actual and ideal amount of time spent on teaching about alternative life styles, sexual values and responsible sexual behavior. These results, presented in Figure 8, also reveal that, for the most part, more or less equal time is spent on all the topics of the FLE curriculum included in the list in Figure 8. Interestingly enough, the least amount of time is actually spent on such topics as improving academic performance, contraceptive use, physical development, and awareness of the opposite sex. Respondents would ideally like to spend the greatest amount of time teaching 9 through 12 graders how to enhance decision making, combined with such topics as AIDS prevention, responsible sexual behavior, strengthening the individual, and consequences of early sexuality and pregnancy.

Healthy Kids, Healthy California, California Department of Education, Gail Maurer

Gail Maurer is from the Department of Education and will discuss the role their agency plays in assisting local schools to develop and offer sex education and family life curriculum.

We are really trying to save the most valuable resource our country has, and that is our children. The California Department of Education believes that the most effective health education programs are those within the context of a comprehensive school health system. We have carefully chosen the word system because education alone does not work. To change behaviors we must not only educate our children with knowledge, but we must teach them the skills and the resiliency to protect themselves in an ever-changing world. We cannot wait until our children are pregnant to teach them about protection. We cannot wait until our children are sexually active to teach them to postpone sexual activity. Together community leaders, teachers, health agencies and parents can model healthy lifestyles to teach our children to be health literate. We have taught our children to be literate in reading, writing and arithmetic. But the California Department of Education really believes that it is time we start teaching our children to be health literate.

What that means is that a health literate person understands science based principles of health promotion. The disease prevention education incorporates that knowledge into personal health related attitudes and makes health a priority in his or her life. I think with all the aerobic classes we see and the fitness classes we see, our nation is beginning to make health a priority.

We have four unifying ideas that we carry throughout our new health framework for grades K-3, 4-6, 6-9 and 9-12. And contextually within that, these themes are carried throughout the framework. First is the acceptance of personal responsibility. Secondly, the respect for and promotion of the health of others. Thirdly, an understanding of the process of growth development. And lastly, the informed use of health related information, products and services.

I teach my children to talk back to the TV. How do we do this? Well, we do it within a comprehensive school health system. A system does not stand alone, but it links community, parents, health educators, and teachers together.

Health education is not just about teenage pregnancy, but teenage pregnancy within a scope of programs where we teach children to be responsible adults. These programs cover health education content areas that deal with personal health, consumer and community health, injury prevention, and safety, tobacco, alcohol and other drugs, nutrition education, environmental health, family living, individual growth and development and communicable and chronic diseases. All of these health area contents are outlined in the health framework with specific guidance to our schools as to how they can incorporate these philosophies that will support these health content areas in whatever manner is appropriate in their particular school district. How do we do that? How do we determine what is appropriate and make it happen? First of all, we turn to our research. Research such as we have heard today. In California we must

recognize our similarities, but also acknowledge our diversity. We do this with an emphasis on behavior, not knowledge. We have to teach our children the skills to protect themselves in the society we live in today. We have to do it in a culturally appropriate way. That's becoming more and more challenging in California where the diversity has increased, and finding that what might be culturally appropriate for one group of individuals is not culturally appropriate for another.

We need to train teachers to be comfortable and competent in the area of health education.

We need to have a variety of teaching strategies, because we all don't learn the same way. Some of us learn by doing, some of us learn by reading, some of us learn by seeing. As a teacher we need to incorporate all of them within the health education curriculum.

We have to focus on both the mental and the emotional health of our children. They cannot come to school without breakfast and be able to learn because their stomachs are growling. A hungry student might feel if they go on welfare because they get pregnant not only will their baby get fed, but they will get fed. And so it becomes very important for us as teachers to acknowledge the needs of our students and help them come to school healthy so that they can learn and they can be receptive to the information.

Use technology; it's wonderful. The games and computerized linkages and systems between our schools can assist us in delivering information in a way that our video generation can accept.

Then, the most important thing is that we integrate this across the curriculum. My strength is in HIV prevention education. What we are beginning to do with HIV awareness weeks are thematic approaches to teaching. All the subjects in the school are teaching on a theme, thematic learning, so that it is integrated, so that it isn't just one teacher in one classroom at one particular hour, but the entire school has integrated a particular health theme that ties them all together; whether it be HIV, whether it be teenage pregnancy, whether it be nutrition or physical education.

Now we have an enormous task in our state because it so very large. Nationally they turn to us and ask for our leadership because we do represent a cross section of the rest of the country. In California, I think we have a little bit of everything that is everywhere else in the nation. We've got 58 percent minority students. That's an oxymoron. 58 is more than a minority. But in California, the majority of our students are "minority" students.

We have laws in California, lots of them. And in health education in particular, there are more than you can imagine. Now one of the things that Delaine Easton, State Superintendent of Instruction, has made a priority is to put the education code on a diet, and hopefully, only end up with those parts of the education codes that are in fact useful, practical and legitimate. In health education, I think we could do that as well.

The law in sex education is: "No governing board of public elementary or secondary school may require students to attend any class in which human reproductive organs or their functions and processes are described, illustrated or discussed, whether such a class be a part of a course designated sex education or family life education or by some similar term or part of any other course which pupils are required to attend." That means that our schools have an option to decide whether or not sex education will be taught in their schools.

I only know of one school district, Hemet Unified School District, who has decided not to teach sex education. One reason they decided not to was because of the controversy that was created when HIV education and sex education were taught in their district. One of the things that our system, the comprehensive school health system does, is create a system where people come together and decide what is appropriate to be taught prior to the instruction so that hopefully you can avoid that controversy.

There are more laws. These are health and safety codes and they apply to our schools the same way they apply to anyone. So in addition to the school education laws, there are also health and safety codes that are very important for our teachers to abide by. One is the law of confidentiality and trust that is established within a classroom. How many of you have had a teacher in school that you trusted and that you confided in? Many of us have had teachers that became our pals. Sometimes it was outside of the classroom on the football field, in your drama class, or your drama club, or an art club. Well, today the responsibility of confidentiality goes a little bit further. If a student comes to you and tells you they're pregnant, if a student comes to you and tells you they have HIV, a teacher has to understand the risks and the jeopardy they put themselves in by helping that student. So I think our teachers today are a little nervous about some of these topics, and therefore it becomes very important as a state department and as trainers to work with them and to help them understand the boundaries of the law and to help them so that they are comfortable and they are protected.

The Youth Risk Behavior Survey contains statistics related to sex education and pregnancy and condom use. The reason those particular items were listed is because it was cosponsored by the State Department of Health Services' Office of AIDS and our department. We have just completed this year's Youth Risk Behavior survey and we hope to be able to publish very soon, a comprehensive youth risk behavior document that will show you the attitudes, behaviors and actions that our students report being involved with for a wider range of health education topics.

One of the attitudes in the field is that if we teach HIV prevention education, we are going to promote sexual promiscuity. But our research has shown just the opposite. In fact, it has shown that those students who have received HIV prevention education are less sexually active, and of those students who are sexually active, more are using condoms and protecting themselves. So the research shows that the sex education and HIV prevention education is effective in reducing sexual intercourse and having children become health literate while understanding the risks.

A variety of teaching strategies can be employed when we deal with the area of sex education, disease prevention, and social skills. Regarding media influence, teach them to talk back to the TV and then use the media to support us. We must work with the media. I think if you look at Seventeen magazine, it doesn't look the same way it looked when I was growing up. It has changed and we need to work with the media so the messages that they deliver are healthy messages to our children.

Peer education is probably one of the most effective means in the area of sex education, and HIV prevention education. Teenagers teaching teenagers with a three-year-age difference; for example: high school aged kids teaching middle school kids, middle school kids teaching elementary kids, has proven to be extremely effective in teaching kids. They listen and, hopefully, change their behavior.

Parent education will avoid some of the controversy. If the kids come home and ask questions and the parents don't know the answers, it puts the parents in a very awkward position. So if schools have parent education before they have the student education, then the parents are empowered to support the school and what's being taught.

In HIV prevention programs we bring people with HIV into the classroom because we believe putting a face on the disease helps children relate and realize that it can happen to them. Often times what our teachers are involved in is making referrals, whether it be to a student who comes to them and says, "Gee, I think I'm pregnant," or "I think I might be sick," whether it is about an STD or they have HIV, teachers need to learn a safe and trustworthy way to do that. They can't be afraid to make a referral, and yet some teachers today find this very uncomfortable. So one of the things our school nurses work on, is how to make an appropriate referral so that they don't have to accept the responsibility themselves but they can refer it to one of those community based organizations who tend to be the experts in the field and help.

What we don't want to have happen is the extinction of sex education. Our goal is really to help support sex education. We do that through local school boards and working with the California School Boards Association, California PTA Association, California School Nurses Association, because we really believe that sex education should be about health education. We also don't want society's expectations, whether it be the media or other adults, to be such that sex is not comfortable. Right now that is a scary word to a lot of people in our schools. But if we can work with them so that our expectations are that we will have healthy sex lives when we are ready, when we are old enough, when we understand it, and postpone that sexual experience until the children understand it, then the expectations of our society can be that we'll have healthy adults.

I think we can do that by having role models in the schools, by teaching our students responsible decision making and refusal skills, and by setting standards of behaviors and community norms that are assessed to be the norms. All too often, all we hear about is what bad things kids are doing. But we need to also shout out loud all the wonderful things that

our students are doing. In doing that then we can develop sensitivity, enlightenment and experiences that are healthy for our children.

I think it is crucial that sex education be taught in a very sensitive environment where the teacher knows more than the anatomical scale, the anatomical model, that they understand it is about relationships and friendships and the world around us and accepting people so that you can build healthy relationships. You do that through skills, empowerment, and higher expectations from our children. If you raise the hurdle, students will jump higher. And we want them to. We find if we teach to the top kids in the class, the kids at the lower level come up and meet that level too. So I think we have to raise our expectations. If we do that, I think that we will have a successful education with exciting futures for our children.

Family Planning and Teenage Services Program, Office of Family Planning, State Department of Health Services, Janet Wetta, M.P.H.

Janet Wetta is from the Department of Health Services' Office of Family Planning to discuss the role family planning and the teenage services program plays in serving teens and the availability of these programs to teens who seek services as a result of learning what these programs might offer them.

I am from the health education section of the Office of Family Planning. I would like to spend the next few minutes providing you with the structure or the overview of the types of health education programs currently being funded by the Office of Family Planning, how those fit into our linkage between clinical services and health education. I will also share with you some of the innovations that are going on at the local level in terms of what activities are being done quite successfully by our different projects at the community level.

The Office of Family Planning funds both clinical and health education programs. There is somewhat of a linkage between those in that at the local level the health education programs work directly with the clinical programs making the connection between the clinical services that are available in the community. Through our health education programs back in 1991 with the advent of Governor Pete Wilson's teenage pregnancy prevention initiative and the beginning of the ENABL, Education Now and Babies Later campaign, our office made a very concerted effort to look at what was going on currently in effective health education family planning programs and to apply those research findings.

We contracted with U.C. Berkeley and ETR Associates to investigate a little bit more in terms of evaluation and application of the research findings. As the basis of all of our health education programs, we encourage the local projects to really use health education curricula, direct education curricula, that have been found to be effective. For instance, many of the programs are using the Be Proud, Be Responsible curricula, the Reducing the Risk curricula, the Postponing Sexual Involvement curricula. We have a number of different characteristics that formulate our programs. There is a direct education program that's both age as well as developmentally appropriate, so that for instance the ENABL project targets 12 to 14 year olds before they are sexually active. This would not be an appropriate curricula or program to go into a high risk area of which many of the youth are already sexually active. The programs are tailored to meet the needs, both age, developmentally, as well as the risk level of the youth.

We attempt to take the comprehensive, multifaceted approach that youth are interacting on a variety of levels, not just in the classroom. They are also interacting with their parents, with other adults, with older youth, with the media, all of which can be influencing points and can affect young people's behavior. We have organized our programs so that they could impact at various levels. One of the challenges to doing a broad based program is how do you effectively evaluate the impact and success of, for instance, a school-based strategy.
Within the ENABL program we have in Southern California is a program that the young people have developed, the Kujchagulia Club, which means self-determination. It is being

used in African American communities as an adjunct to the ENABL program, something that was developed by the young people. It uses the same messages of postponing sexual involvement, and once again, reinforces throughout the community and throughout the year, not just in the five sessions the young boys and girls get through direct education, to expand and build upon the program that is being offered.

This is the direct education. There is also what we call community/school-wide agency-wide awareness and involvement activities. Activities might include everything from poster contests, artistic competitions to rap contests, within the school setting itself. We look at the school as a community. It's a place where young people spend a lot of time. They are being impacted day to day and their peer norms, group norms, are being influenced and shaped at that particular level. So we look at the school really as a community in itself, as well as the larger community.

We also have as a part of the comprehensive program parent education and involvement. Parents, we know, want to be involved in their child's sex education. They want to be able to communicate with the young people better. But it is also very difficult to recruit and to identify and implement successful strategies for involving parents.

Project success really depends on the school and the administration's support. If an agency goes in and they want to recruit and involve parents and they have the support of the administrators and of the individual teachers, they are more likely to have very high parent involvement. We have had projects that have done innovative things like working with the teachers to give the kids extra credit, if the parents come out for the parent presentations. Also having individual teachers who make contact with every single parent in the school to remind them of an upcoming parent education night. We really have some committed schools, teachers, as well as local programs.

Our programs, both ENABL, which serves the 12 to 14 year olds, as well as our Information and Education Programs, which reaches age 9, elementary school through adults, all have the direct education, the parent/school/community-wide approach, as well as local media activities. In addition to that, there are also two bookends to the programs. One of them is the reproductive health. One of the effective characteristics of direct education curricula is that they have a focused approach, that there is one consistent message that is being given, and that it fit into a broader comprehensive program. We know that young people need more than just the skills of how to say no, of how to use effective contraceptives, how to talk to their parents. They need anatomy and physiology information. Programs are more effective and young people are more likely to listen to other program messages if they have a good, solid reproductive health program prior to receiving the focused consistent message.

We find, for instance through the ENABL program, that educators, whether they are teenage leaders or adult leaders, who go in to provide the five session PSI program get more off-target questions regarding reproductive health, contraceptive methods, and various things, if the students didn't have the solid reproductive health program before hand. We are very much committed to continuing to work to get family life education training programs for the

teachers so that they can be trained in how to effectively teach these types of programs and have more comfort with the material.

The other bookend is this whole notion of the linkage between health education programs and clinical services. That very much varies according to the program, because it is dependent on community acceptability and community level support. Most of the I & E and ENABL projects that do work in the community involve the individual school districts, the schools, negotiating what type of process is acceptable for that particular community and would be acceptable to the parents. It's part of the open communication and dialogue. We find that projects that approach it from a win/win perspective, that go in and say, "We really want to help the young people, we want to make this an effective program, what can we do to satisfy your needs, and what are your concerns," are much more likely to have success implementing a family life education program within the school than those that go in with the perspective of saying, "Those people just don't want kids to have anything." That is something that has been very effective.

For the referral process, we do know there are many young people that are sexually active by the time they reach high school and that there needs to be a means of linking them with the services and the information that they need. Many projects provide a referral card that includes family planning services, but it is not limited to family planning services. It also includes such things as mental health counseling, abuse services, runaway hotlines, shelters, and various types of other services that address family and school difficulties that young people might be having.

I think it is a very exciting time for our office in terms of the past five years. We really have been making the move towards looking at what is currently going on in direct education, in research, to see how it can be effectively applied to our programs, making that information available to the people that are actually delivering it at the local level and providing training opportunities so that they can also become skilled and educate their communities with that information.

Substance Abuse Prevention Programs, State Department of Alcohol and Drug Programs, Arlene Roberton

Arlene Roberton will discuss how the State Department of Alcohol and Drug Programs (ADP) strives to prevent or reduce substance abuse among teens, particularly teenage women, and the extent to which these programs address other risk-taking behaviors such as sex.

The Department of Alcohol and Drug Programs deals with high risk behaviors that are connected with teenage pregnancies through statewide prevention programs. We found that we need to do more than just talk to kids about issues, and we have come a long way from "Just Say No."

I'm going to go very quickly through some of ADP's programs that are connected with teenage pregnancy. Our perinatal substance abuse programs are not prevention programs, per se, but through them we work with other state departments that have programs like the Adolescent Family Life, ENABL, and the Cal-LEARN program. We work with their case managers and workers who are training other people to identify alcohol and drug problems so that they can be aware of them and the referral agencies with which they can work in their areas.

ADP is interested in increasing the knowledge in local communities, so we're finding ways to collaborate and integrate our services with other state departments in the arena of perinatal substance abuse. In our prevention programs, we used to deal more with programs that were small, in the communities and small demonstration projects. What we've learned through the years is that we need to enhance our environmental strategies. We work a lot in communities with city planners in identifying how to change the way the community is developing to alleviate some of the high risk areas and some of the behaviors that are going on there. We focus a lot of our energy now on what we call "environmental strategies" in dealing with substance abuse.

I'd like to mention some of the programs. We have demonstration projects, some of which go for three to five years. We also have ongoing projects. Friday Night Live and Club Live, go on in the school systems, although in some counties, they do not. Some are at local Boys and Girls Clubs and other groups like that. But mostly they happen at the school sites. The Friday Night Live and Club Live programs deal with self-esteem, resiliency, teaching leadership skills and about other resources within their communities where they can learn different things. We estimate that we reach a million students a year through Friday Night Live and Club Live programs.

We also work with the Partnership for Drug Free America (PDFA) which are the commercials you see on television every once in a while. PDFA is moving in the same direction we are with the environmental strategies. The commercials used to be more targeted towards the individual. The first ones you saw a couple years ago were directed towards the user. Research tells us the user is not paying attention to the commercials and not acting on them. So what we've done is move toward targeting individuals that are connected somehow with

the users and the community. You will see new commercials coming out this fall that talk about community involvement, what you can do, how you can care about the community and its kids.

Like everyone else, we are moving towards getting the community involved. Through the PDFA, our department sponsors Partnership for Drug Free California. We take those commercials, put our tag line on them, and make sure they are distributed to all communities. We do press releases, follow-up, make sure those things are happening in California.

ADP sponsors an annual Teenwork training event. Last year 600 high school students participated. We invite high schools in high risk areas to send students. We sponsor the students, and Teenwork deals with a lot of the issues about self sufficiency, skills building, and community involvement.

Here in Sacramento, in Oak Park, we have the DESTINY project. It is a different type of school based project. One of the things DESTINY is responsible for is reaching high risk students who aren't already being reached by the education system. This project reaches out to kids who haven't finished high school, brings them back into the high school environment and tries to get them involved either by training them to use computers so they can get a job (vocational training), or by helping them to get their GED. We are doing an extensive evaluation of the project. We expect to learn a lot from the evaluation, which we will distribute to other communities as an example of how to reach those students that aren't in the education system.

We have community drug free school zones and high risk setaside youth projects. We work with other state departments such as Office of Criminal Justice Planning on gang suppression projects, and all the DARE and DARE-type projects are funded by our department. We are working with Department of Health Services on some of the tobacco projects. I can go on and on about collaboration, but the message is that we are integrating alcohol and drug abuse knowledge and programs into other departments that serve the same populations. We don't focus on teenage pregnancy specifically. It's up to the community to do that; although we do have one program in Nevada County that has a substance abuse program and is targeted for pregnant teenagers. We are hoping that that will be a model for other programs in other communities.

1995 CAFIS TEENAGE PREGNANCY PREVENTION POLICY ROUNDTABLE SERIES

Policy Roundtable #4: Preventing Repeat Pregnancies

THURSDAY, JULY 20, 8:45 A.M. - 12:00 NOON
LIBRARY & COURTS II BUILDING, 900 N STREET, ROOM 340
SACRAMENTO, CALIFORNIA

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:05 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:05 - 10:05 A.M. ***PRESENTATIONS***

M*ary Wagner, Ph.D., Program Director of Education and Human Services Research, SRI, International*. She will discuss her evaluation of Teen Parents As Teachers, a program funded by the State Department of Social Services. (20 minutes)

Renee Cameto, Research Social Scientist, SRI, International. She will discuss her evaluation of the Young Teen Parents Collaborative based in San Francisco. (20 minutes)

Terry Carrilio, Ph.D., Project Director, South Bay Home Support Project, Center for Child Protection, San Diego Children's Hospital. She will discuss their new home visitation program and how, among other things, it will reduce repeat teenage pregnancies. (20 minutes)

10:05 - 10:15 A.M. ***BREAK***

10:15 - 11:05 A.M. ***STATE PRESENTERS/DISCUSSANTS***

Sharlyn Hansen, Adolescent Family Life Program (AFLP), State Department of Health Services (10 minutes)
Ronda Simpson-Brown, Consultant, School Interventions & Educational Options, California Department of Education (10 minutes)
Jane Boggess, Ph.D., Chief, Office of Family Planning, State Department of Health Services (10 minutes)
Marjorie Kelly, Deputy Director, State Department of Social Services (10 minutes)
Nancy Remley, Manager, Cal-Learn Program, State Department of Social Services (10 minutes)

11:05- 12:00 NOON ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

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POLICY ROUNDTABLE #4

PREVENTING REPEAT PREGNANCIES

Teen Parents As Teachers Program, Mary Wagner, Ph.D.

Dr. Mary Wagner is Program Manager of the Education and Human Services Research Program, Health and Education Division, SRI International where she has worked since 1980. She specializes in program evaluation, research design, quantitative analysis of individual-level data, survey methodology, qualitative research methods, policy implication analysis, and integration of multimethod research approaches. Dr. Wagner is director of a number of major evaluation and research projects, including parenting education and family support interventions.

For those of you who aren't familiar with SRI, we used to be called Stanford Research Institute. We are now SRI, International, in Menlo Park. I have had the pleasure of directing a program of analysts who are looking at a variety of education and human services interventions for vulnerable kids and families. Healthy Start was mentioned, and we have several evaluations going on. Two that we are going to talk about today have to do with two specific interventions for teenage mothers. One is called the Teen Parents As Teachers demonstration project, and I am going to spend most of my time talking about some findings from that demonstration. My colleague, Renee Cameto, will be commenting on that study as well as the one in San Francisco that she is doing with the Family Service Agency there, on middle-school aged mothers, mothers that are under 15 years old, the Young Teenage Parents Collaboration.

I was worried as I began preparing some of the findings from the study that there was not a lot of good news to share. I was relieved when I read the CAFIS background report discussion on repeat pregnancies to see that preventing subsequent pregnancies for young mothers who have been pregnant at least once before is a tough job. We have not yet found interventions that work very dramatically in that area. I think we are committed to and accepting of the need to deal with this issue and yet we are frustrated in looking around at the options because we don't see any magic bullets.

The interventions that we are going to talk about today aren't any of those magic bullets either. But let me describe what has been tried, because I think learning from what we've tried is going to help us hone in on what may be a better combination of services for young mothers. Let me tell you what the Teen Parents As Teachers (TAPP) demonstration is about, and then I will share with you some findings from its first year evaluation, and one finding from the second year data. The data from the second year of the evaluation were supposed to be ready tomorrow. I actually pressed our programmer to get one number ready for us today, which is the repeat pregnancy rate. She was able to do that by working real hard. So I won't be able to tell you too much about what happens when mothers are two years past the birth of their first child.

The Office of Child Abuse Prevention (OCAP) was the initiator of the TAPP demonstration. Using Children's Trust Fund money, OCAP wanted to test the hypothesis that Parents As Teachers, which is a standard curriculum home visiting program, could have benefits in terms of child abuse prevention for young mothers. We all know that the children of young mothers are particularly at risk for child abuse because of the economic, social, and emotional stresses that young mothers encounter. They often deal with their motherhood without proper support. There are all the economic disadvantages of poverty that often accompany that. More and more we are learning that they are also dealing with their own issues of sexual and physical abuse and power issues with their partners. It is a stressful situation for young mothers, and frustration often is expressed through physical abuse or emotional abuse to their children. So OCAP believed that, by teaching young mothers parenting skills and giving them good information on child development, some reduction in child abuse might result.

The Parents As Teachers model had been initiated in Missouri years ago, and is now statewide in Missouri. It is now in many countries around the world, in fact. It is a well-tested and evaluated model, but it has never been adequately tried for teenage mothers. Does the curriculum, does the approach of monthly home visits by parent educators, work for mothers who have lots of issues going on, besides not knowing very much about parenting.

The idea was to look at Parents As Teachers as a child abuse prevention measure, and to also look at it in a variety of other ways. To look at it alone, if that was the only intervention being offered to young mothers. To look at it in combination with comprehensive case management, as is carried out by the state's Adolescent Family Life Program (AFLP). Do you get more bang for your buck when you put them together? And then to compare those two models to case management alone and to no services at all. This is the experimental design. We had random assignment of more than 700 young mothers to these four groups: the control group, Parents As Teachers only, case management only, and a combination of TAPP and AFLP.

And the idea here is that case management has traditionally dealt with the mother's issues. For instance, teaching is focused on the kids; it is child development. And the mother is considered a mother and not a teenager in that program. By putting them together, maybe you get the best of both worlds. And so we are actually dealing with a variety of hypotheses here.

Four sites were funded: San Bernardino County, San Diego, LA and Santa Barbara. We have been the evaluator of this for some time now. The treatment, the intervention, was administered to young mothers with children up to the child's second birthday. The evaluation measures outcomes for the children, we do child development assessments, and more traditional case management outcome measurements when the children were one year old and then again when they are two years old. It is the two-year-old data that I don't have yet. So what we are going to talk about mostly is what happens at one year with regard to repeat pregnancy rates.

The intervention itself is meant to provide monthly interaction with the mother. So the parent educator goes to the home, wherever that might be, visits the teenager. Actually, the educator tries to go to the home -- in fact, the chaos in the lives of the teenage mothers has made it very difficult just to deliver the intervention. They are not there where they were a month ago. In the focus groups we have carried out, Renee will talk about the chaos in the lives of the young mothers that was eloquently brought out in the young mothers' own words.

We had a lot of trouble ever even delivering the intervention. Monthly home visits were not productive. A sense one of the first things we learned was that this standard curriculum, which depends on that level of interaction, doesn't work very well at the caseload level that a Parents As Teachers parent educator typically carries. A parent educator typically carries up to 50 families and is able to deliver monthly home visits to 50 families, if they are more traditional families of a more traditional age spread. It doesn't work when you are trying to deliver home visiting services monthly to young mothers. So one of the lesson learned was just how difficult it is just to get there.

The case managers had similar kinds of issues of finding the young mothers, but were in fact more successful in doing that. The level of intervention was somewhat more intense for case managers. They also used phone contact as a more effective vehicle for delivery. Parents As Teachers visits aren't delivered and child development lessons are not delivered by phone, but a case manager can do a lot of her work by phone. So we are looking at aspects and levels of intervention and what difference does it make how much of the service the young mothers received.

Before I talk about repeat pregnancy rates, one other thing I wanted to mention is that I want you to have a clear picture of who the participants were in this demonstration, because we are not talking about a broad cross-section of young teens. This is not a statewide sample. It is a very particular group of young women, and I want you to understand who they are as a way of understanding some of the circumstances that they face. Again, there were about 700 young women that were randomly assigned to these four groups, and more than half of them are Latino.

Again through the focus groups we came to appreciate the difference in the particular characteristics of the attitudes, the backgrounds, the role of women in that culture. That has such a lot to do with the decisions to be made and the ambivalence that they feel about motherhood and repeat motherhood as teenagers. The Latino mothers were concentrated in two sites in particular: Santa Barbara and San Diego.

Twenty percent of our population was African American. They were concentrated almost entirely at El Nino Services in South Central LA. So that is a program that serves almost entirely an African American population, and it is very urban and very center city. The 20 percent of Anglo mothers that we had were concentrated, more of them in San Bernardino than anywhere else, although there were a few everywhere. Some of the ethnic issues that we are dealing with are also program issues, and it is difficult to disentangle the two.

Virtually all of them were on public assistance. Lots of non-poor teens get pregnant. That is not what we are talking about in this demonstration. These are poor young women, very poor young women in many respects. Sixty-eight percent of them, about two-thirds, were still at school at the time they enrolled in the program. One of the issues that we looked at at some length is the school attainment of the young women after they delivered. In fact, because we have reasonably small samples here in our first year evaluation, we saw some indications that, particularly the combined intervention, they capped the dropout rate at the same level as enrollment. Usually more and more of these young women drop out. Two-thirds of them started out enrolled, and that drops off after they deliver. The combined intervention was able to cap that. Some young women dropped out, but more of them reenrolled. So the combined programs were able to keep a lid on the dropout rate, whereas in the control group after just one year, there were 11 percent more dropouts. So we think one of the things we are most eager to look at in the second year of the evaluation is educational attainment because we know that young women who see a future and are in fact invested in activities outside the home tend to have subsequent pregnancies delayed for a longer period of time.

Twelve percent of the young mothers were married; these women were virtually all young Latino women who are married. The average age was 16.5. Forty-two percent of them, though, were 16 or under. The father's age was on average more than three years older. In fact, 47 percent of them were over 20. So there is quite a discrepancy in the age of the father, when the father could be identified and the age reported. In fact, there is a large proportion of them for which the father's age is unknown. Keep in mind who these women are as we talk about some of their experiences with teenage pregnancy.

Let us first look at the control group first. Keep in mind that control does not mean "no treatment." It means these are kids that are getting whatever is ambient in the community. They might be participating in some parenting program in their school. They might be getting some kind of services from some place. But they are not getting services from here, and that is important. It is not that there is nothing going on for those young women, they are finding or receiving whatever they could find in their community. They are just not getting Parents As Teachers, AFLP case management, or both. We then wanted to get a broader perspective on how these kids compare to the statewide numbers. With Sharlyn Hansen's (from AFLP) help we were able to get a one-year slice of AFLP participants also measured at their child's first birthday. They are demographically not like these kids, though, which made them a tough comparison. Through the wonders of statistics, made them look like these kids. We adjusted the AFLP sample for ethnicity and age so that that there is the same age distribution and the same ethnic distribution.

What we see by the child's first birthday is that, left to their own devices, 21 percent of these young women either were pregnant at the time or had a pregnancy in the previous year. That is in the control group. There is no difference statistically between that number and the numbers for any other intervention program at one year of age. We see 21 percent for case management, 20 percent parent education, almost 19 percent for the combined intervention. It looks like other AFLP participants around the state. That just seems to be kind of the ambient level of repeat pregnancies that occurs in that one-year period. Actual live births

were marginally lower from the intervention, which means that there may actually be some delay in the onset of the pregnancy. There are just as many pregnant, but fewer of them have already delivered, so the pregnancy wasn't happening quite as quick in the intervention period.

We then asked if between the child's first and second birthdays, was the mother pregnant or had there been a live birth or an incomplete pregnancy in the last year. We see more of them had had a live birth at that time, so it is like they are shifting to the second year period. They are pregnant at one year, but they are shifting that birth into the second year period rather than having the birth in the first year. So we think there is some indication of delay. Again, these numbers came out just a week ago, so it is going to take a lot of analysis to disentangle some of those things. We think they are reporting abortions as incompleted pregnancies. The word "abortion" does not occur in the AFLP data base or on the form, but where there was a pregnancy that isn't anymore, that's where they write it down.

You can't just add these numbers together to find out over a two-year period how many were pregnant, because you can be pregnant in the first year and deliver in the second. What we found in the control group is 39 percent have been pregnant at some time in that two-year period, had delivered a child, or was pregnant at the two-year birthday. Thirty-nine percent. There is no statistical difference between that number and the numbers in any of the other groups.

We investigated that in a meeting of the case managers and parent educators in January. What is going on here? We know preventing repeat pregnancies is their highest priority. The first thing the case managers do is try to get them on birth control. The thing that is most important to us is to prevent that second pregnancy from happening too soon. If they are going to get pregnant again, we want it to be a planned pregnancy. We don't want them to get pregnant by accident again. And yet it is happening over and over again. We are going to be looking at the reasons for that, and I've got the information here on factors which were associated with it.

One thing, obviously, is contraceptive use. During the same period between the child's first and second birthday, what the mother's contraceptive practices were. We also asked in focus groups of young mothers: What was going on when you got pregnant the first time? What was going on when you got pregnant the second time? How about the third time? There are actually mothers still in this program that now have three children, though not very many. Even after a year of the program or their child's first birthday, fewer than two-thirds were reporting continuous practice of contraception. About 13 to 18 percent say they are abstaining from sexual intercourse at the time. But it means that only between 70 and 80 percent are actually protected again subsequent pregnancy. Not surprisingly then, 20 percent have been pregnant. Contraception is the way you don't get pregnant, and there is only 80 percent of them that are doing that accurately and adequately. And the other 20 percent have been pregnant, so there is great validity in the data.

It doesn't get any better by the second year. These case managers are knocking themselves out to bring home this point, and the young mothers talk about how they can't ever walk in

the house without the first thing they say is, have I had my shot. They are really doing the job, both the moms and the case managers talk about how much they beat that drum. Yet we see now that after two years of the program, the rates are still virtually identical to the control group. In fact, they have gone down marginally. The idea that it is all about information on contraception is an inadequate answer to this problem. There is a lot going on. The workers take them to the clinic to get the shots. Medi-cal pays for Norplant, and still we have 20 to 30 percent of these young women who just don't participate in contraception.

Some of them plan a second pregnancy. That's the right of any young woman, to have a child. But lots of them say, no, the second was an accident too, or I was taking my pills but I wasn't doing it very regularly, or I went but they couldn't give me the shot because I was sick and by the time I went back to get the shot again, I was pregnant already. There are lots of stories about it just falling apart, the contraceptive practice, and what it takes to get it right is beyond the abilities of many of these young women.

Let me just briefly talk about some of the factors that seem to be associated with the repeat pregnancy rates. Again, this is the percent that have been pregnant in the year between the first and second birthdays. These are data from the second year measurement. We asked, are you pregnant now, or in the last year have you been pregnant? Obviously it related to contraceptive use. Almost 46 percent of those who never used contraception have been pregnant in that year. Those who used it sometimes have a little better success. Even those who say they always use contraception, though, which "always" is a "sometimes thing," 23 percent of them have been pregnant in that year, even when they say they are getting it right. Those who say they are not sexually active, 11 percent of them have been pregnant, too. You have to wonder.

We know something about high school involvement and repeat pregnancy. And we see it dramatically here. For those who have graduated or are still enrolled at the time of their child's second birthday, there are still high numbers of repeat pregnancy. It is 29 percent or 24 percent, but it does not approach the 49 percent repeat pregnancy rate in that one year period. This is not over two years, this is just in that one year. Among the dropouts, 90 percent were reporting second pregnancies, or third, in some cases.

We also looked at father's age. One of the things we fail to pay enough attention to is the male factor here. These young women are involved with men who are older than they are. They may still be teenagers, but when you are 13 and the guy is 19, that is an older man. We have a lot of that going on here, and age has a lot to do with whether this young woman is pregnant again. In fact we see the rates escalate greatly by the age of the father. We also know that these fathers are less likely to be high school graduates, even than the mothers. Their educational level is on average lower than the young woman's. And when we talk about the barriers to completing high school, the father not liking it is mentioned over and over and over again. The jealousy over the mother's educational attainment exceeding the father's is a big problem for these young women. They are fighting a man who is older than they are, so power is already on the other side. And he hasn't completed school, so she is not going to. Over his dead body, kind of thing. It is unusual to hear a report in the focus groups

of support for continued education and support for postsecondary education from the males that these young women are involved with. The repeat pregnancy rate is 40 percent among those whose male partners are less than 20.

Young Teen Parents Consortium, Renee Cameto

Ms. Renee Cameto is a Research Social Scientist in the Education and Human Services Research Program, Health and Education Division, at SRI International. She specializes in design, implementation, analysis and reporting of quantitative and qualitative research with a focus on program evaluation and policy implementation.

The Young Teen Parents Consortium (YTPC) is a special program that grew out of the Teenage Parenting Project (TAPP) in San Francisco run through the Family Service Agency.

And I just want to describe very briefly the differences in those two programs. YTPC originally accepted pregnant teens who were 15 and younger. With many young teenagers getting pregnant, they now limit it to teenagers who enter the program when they are 14 or younger. Like the TAPP project, they receive AFLP case management, although YTPC gets very attentive case management. It is initially almost weekly contact with the case manager. Nearly all of the teenagers attend an onsite Pregnant Minor Program school where the case management occurs. And the young teenagers get an extra semester there after the baby is born. In the program all of the teenagers receive basic child development education, but the youngest teenagers get an additional semester and additional hours almost four times as much.

Also part of this special program is the child development specialist who teaches these classes. In addition to the classroom activities on a daily basis, this specialist also provides essentially an open door to counseling and has contact with these teenagers. Essentially, the teenagers talk about her as their other mother, the mother who they depend on, and the mother who gives them the information that they rely on.

Child care is available now to teenagers who are Cal-Learn eligible. When the YTPC demonstration began, part of that was that the teenagers in the program receive child care. They had transition placement onsite for the baby after the baby was born and they were educated in selecting a family daycare site and the sites were monitored through the Children's Council.

The teenagers are very much like the teenagers that Dr. Wagner described in the Young Teen Parents Program. They are almost all young women of color; essentially, only four percent are identified as white. Again, as Dr. Wagner said, these are teenagers who are in relationships with much older men. For 10 percent of them the father of their baby is their age peer.

There are some positive outcomes. We see that for the teenagers that have been in the program for a substantial period of time and come in the first or second trimester, they have all babies born with normal birth weight, and that certainly was a concern. They have high rates of immunization, and they have very high levels of wellness checks for the children.

They have a really good reenrollment. School seems to be a really strong factor in postponing a repeat pregnancy. When the teens entered the program, 22 percent of them had dropped

out of school already. At birth, however, there are no dropouts. All of that 22 percent were reenrolled. As Dr. Wagner suggested in TAPP, there is some success in reenrollment of teenagers. And clearly in this program they have reenrolled everyone. The other interesting point here is that 93 percent of them are actually onsite in the pregnant minors program. Ten percent are still there after 12 months. All of them can stay six months after the birth, and then they start being transitioned out. That is quite different from other projects. By 12 months, we are back up to a 25 to 26 percent dropout rate. It is this transition time when they need that onsite program that YTPC loses a lot of girls. The staff there say that this is the critical time because the increases in school dropout are normally only about 5 percent up to that second year. So that is clearly the critical time. There is some work that needs to be done here, and staff feels that it needs to be onsite through that young woman's entire high school experience in order to keep them and get them educated.

The total repeat pregnancy rate is about 20 percent in the first year and up to 30 percent in the second year. This really isn't any different from the other AFLP programs at those time frames. It seems that maybe, as Dr. Wagner was suggesting, that there is a little bit of a delay here in second births. There is a slightly lower birth rate. It may be there are a greater number of pregnancies being terminated. But the data on that is just not really very clear in terms of how those items on the AFLP forms are responded to.

What is going on with the contraceptive use? Around 65 to 70 percent of the teens are protected, but that means that 30 to 35 percent are not. That means that the nevers and the sometimes, and as we talk to them, even the ones that say they are taking birth control or are using some sort of contraception, that it fails them or they are not being as faithful as they ought to be.

There is some increase in the use of Depo-Provera over the year. There is an increase in the use of the pill, and a decrease in the use of condoms only. This is at the 12-month follow-up and the 24-month follow-up. The teenagers and staff say that Norplant and Depo-Provera are preferable to having to take the pill on a regular basis. These contraceptives are more reliable, but the teenagers talk so much about side effects.

What are teenagers thinking about contraception? So many of them have all kinds of misconceptions and misinformation. "My periods were irregular, so I didn't think I'd get pregnant." This is a woman who has two children. "I was using the pill, but I guess I didn't take them regularly." "I thought I'd be protected for a year after I stopped taking the shot." "He said he would pull out, and I wouldn't get pregnant." "He said it doesn't feel right with a condom." We hear this over and over and over again, that they are so strongly influenced by the man that they are with and what they want.

As Dr. Wagner said, the parent educators say contraception is not part of their job, it is not their responsibility, it is not part of the parent education curriculum, and still they talk about it. It is, however, part of the role of the case manager. The teenagers say their case manager or educator is always asking, "Do you have the pill?" "They stay on you." "She will ask if I'm having sex and using protection." "She brought condoms every time she came." "She really,

really wanted to make sure I got my shot on time." "She'd take me to the clinic if I needed something." They do talk openly with their case managers or their home visitors. I think that in their homes, their ability to talk about sexuality, to talk about pregnancies and that sort of thing, is really difficult for them. "I couldn't talk about sex with my mother. All she could say is, you don't give it up until you are married." "My stepfather talked to me about sex, but I don't like talking to him because he gets upset when it comes to talking about sex." "My mom was raised that you can't talk about sex. My auntie says, I know you are going to do it, so take these condoms." By the way, that's all that auntie said. She didn't give her any more information, she just gave her the condoms. "My grandmother didn't even tell me about menstruation." "My mom wouldn't talk to me about menstruation. She was so tense she told me to go see my sister." "My father told me I'd get fat on birth control pills, so I don't take them." "When you ask for advice, you get a lecture." "Having a baby made it easier to talk to my mother."

We find that these women get a lot of positive reenforcement from being a mother. It is perhaps the first time that they have ever been really accepted, that they have assumed or achieved the role of a woman in our society. They get physical attention in their visits, their babies are cute, they get love from that baby. It is a very positive experience.

I have to say that I was very strongly affected at times when I would be in a room with ten teenage mothers and every one of them had been sexually abused. They don't make the connection very often between that kind of abuse and their current behavior. But you can't help but be affected by knowing that they all have been sexually abused and then listen to their talk about violence in their homes and worrying about their own children being abused. An ex-gang member said there is a lot of rape in the home. This was a matter of fact statement. "I can't live with my stepfather, it upsets me." He was suspected of abuse, and this young woman had been in and out of hospitals with asthma and ulcers. "I wonder sometimes why I do the things I do. Is it because of what happened to me as a kid?" This young woman was sexually abused by her stepfather. He was sent to jail and when he got out he went back to live with her mother. "He had mental control over me. I wasn't good enough. He was tearing me down. My parent educator made me realize that I didn't need to put up with his abuse." This young man has been in jail for domestic violence. He is getting out in August, and this young woman has moved home again to live with her mother for safety.

We also conducted focus groups with case managers and parent educators. They say it is hard to work with a teenager when she is in crisis or unstable. They can't focus on their other needs. Dr. Wagner has alluded to how teens move around. Literally, they can be in four, five or six homes in the same year. The young woman whose stepfather went to jail and when he got out and went to live with the mom, the mom put the young teenager out on the street and she was homeless with her baby. So these are really, really upsetting situations that you hear about. It is not uncommon for a teenager to live in several places in the course of a year. She was in foster care, with a friend, and in street clinics. Their own violence and abuse is at the core of their lack of self-esteem. They don't take care of themselves or value themselves. I think this has a lot to do with how they handle contraception.

Teenagers harbor a lot of myths and misinformation from friends and family about birth control. They expressed many contradictory ideas. They have information from their case manager or their parent educator, but they also have information from their partner, the father of the baby, and from their families. We've had girls describe to us that their mommies and their grandmas are from Jamaica or from Puerto Rico and have all kinds of folk medicine practices that they are pressuring these young women to use. They are living in the home with their grandmothers or their aunties or their in-laws, and so they are with those people every day.

The girl's sexual abuse and physical abuse has not been dealt with therapeutically. This becomes an obstacle to the girl's benefiting from assistance. We asked the teenagers what they thought they would need, and they wanted more information on abuse. They thought that the fathers of the babies needed to be helped. Just one out of over 50 teenagers that we talked to said that the father had been in a parenting program, and she said, you know, he doesn't go out with his friends any more, he actually stays home and wants to be a parent. These are young women who, although they are strongly affected by the older men, are raising these babies by themselves with lots of misinformation.

South Bay Home Support Project, Center for Child Protection, San Diego Children's Hospital, Terry Carrilio, Ph.D.

Dr. Terry Carrilio is the Supervisor of Family Support Services, Center for Child Protection, San Diego Children's Hospital. She has experience in direct clinical practice, policy, program development and implementation, as well as community and agency based field research. Dr. Carrilio will discuss the teenage parent home visitation program she directs and, as time permits, the new Healthy Families America home visitation they will soon implement.

The part of Children's Hospital that I am associated with is the Center for Child Protection. The Center for Child Protection has many programs, not just home visiting. For example, we also have an evidentiary clinic and a treatment program. One of the things I would eventually love to do is follow up with some of the kids that come through that program. I am not sure I would like what we would find, but I'd like to have the information so we can do a better job. I believe that the "best practice" model is a triumvirate between the policy, practice and research. In the Healthy Families project we have achieved that, and I am very happy about that.

One of our Home Visiting programs has been operating since 1976. That is our Parent Aid program where we have had volunteers working with what we call "overburdened families." Let me quickly describe for you what an overburdened family is. An overburdened family is a family with multiple problems, dealing with multiple systems, in which you have parents, usually the mom, with a number of very serious problems. Usually there are identity problems; by that I mean they don't know who they are and they have difficulty maintaining continuity in their own identity. That is very important. They can appear to be different people from time to time.

The second thing is very, very low self-esteem, usually stemming from the violent homes they come from, and frequently from their own abuse histories. Many of our families have attachment problems in their own families; therefore, they are going to have attachment problems with their children. Many of our families fit what is described as "learned helplessness." One of most serious issues in dealing with an overburdened mom is that she has no idea that anything she does has an impact on anything that happens to the child. She may view her life as a movie that she is watching. These things are "happening" and they have a very hard time imagining that something they do can relate to outcomes for their child. Often they also have additional problems, such as poverty and low education.

With our teens we find highly unstable living situations. We find sometimes the mothers' living situation changes several times in a month. Some of the teens we work with are very high risk. Their own parents are substance abusers; a lot of them were thrown out of the house at 11 or 12. Many of them describe an experience where at about 12 or 13 their mother decided the teenage was grown up and the mother was done parenting them, whatever parenting they were getting up until then. They also come from homes where their own parent, their own mother, is a prostitute or substance abuser and tries to get them into that.

So for them, hooking up with what ends up to be an abusive relationship is actually a step up and out, which actually makes it hard to separate them from some of their boyfriends.

Our Teen Program is a cooperative program between Children's and Sharp Mary Birch Hospital. Mary Birch is the largest birthing center in San Diego County; they have about 16,000 births a year. About 7 percent of those are teenage moms. We are expanding our program at Sharp into the South Bay, which is very largely Latino.

There are new Parent Support Programs on all the Marine bases in the world and on 20 (soon to be 30) Army bases. It is a combined child abuse prevention and domestic violence prevention program. This program follows in many ways the Healthy Families model, since they screen families at birth and follow them for a sustained period of time.

The South Bay Home Support Project is our contract with San Diego County for early intervention and prevention services. We deal with cases that have already been identified as having problems. The Healthy Families Program, that I hope I have a little time to present, is co-funded by the State Department of Social Services, Stuart Foundations and the California Wellness Foundation. We are working to develop an "optimal home visiting model" similar to what has been operating for a while in Hawaii. The question is, can you transport this to a different environment? Hawaii has its own unique environment with a population smaller than the county of San Diego. So to do something statewide in Hawaii is a different animal than trying to do something statewide in California.

I am going to describe what we do in our teenage program. Our home visitors, our concept of case management is a little different than the model presented by others today. Our home visitors are part of the case management team. We do all of our work in teams. What we are trying to do in our teenage program is to promote positive parenting. That is the focus on the child and on the mother/child interaction. We help these kids who may not have good relationships in their lives to recognize how to identify and meet their child's needs.

I don't know if any of you have had the experience, but a lot of our teenagers will do things because they have little knowledge about how to parent or interact with a baby. As an example; they prop their child up in a little car seat, punch a big hole in the nipple, stick it into the child's mouth, and you will see this baby literally drowning in milk. They think they are being a good parent, because the baby is drinking milk. So we have to start with that, why it is you shouldn't just sit the baby there while you are "hanging" with your friends with the baby gurgling this milk down and strangling. They don't realize it; they don't recognize it; and they don't see that the baby is struggling. They really need very specific help in understanding and interacting. We also focus heavily on continued personal development and that includes many things, among them finishing school, planning your life a little bit, and preventing child maltreatment.

These are some of the specific objectives we have in working with our teenage moms. There is an educational component. There are very concrete skills: how do you change a diaper? How do you know when the diaper needs to be changed? Most of these kids have no clue;

they have never seen it, they have no experience of what it looks like to do it "right." They don't really know. They also don't have a lot of money, and so they are more likely not to want to change diapers too often, not to want to change the outfit too often, and so sometimes their kids are in pretty bad shape because they don't know and they don't have the resources, they think, to manage better.

The Director for the Center for Child Protection is a pediatrician and he is quite interested in the health needs of the children, as are we. We work very hard to get them in for all their well-baby care and to help the moms recognize quickly when they have things like an ear infection, a cold, or food allergies, so it doesn't become something more serious.

We also focus very heavily on the positive interaction with the child, making eye contact, talking to the child. A lot of the teens don't know that you are supposed to talk to the child. They think the child is just this thing that you carry around, like an accessory. I have seen these moms who will sit there and talk to you while they are hitting the baby woodenly to burp it. Their idea of burping is noninteractive. They are just woodenly hanging on to this baby and whacking it. They are telling you, see how good I am, I am burping my baby. And you are saying, well, just look at the baby and see what it needs here. We work a lot with them on connecting with their babies.

I think if we are looking at long term outcomes, the continued personal development of the teenage mother is really where it is at. Sexual responsibility and planned child bearing is our topic today. But it is really part of a larger picture. I don't know that we can look at subsequent pregnancies without looking at whether this girl has a view of the future? Is this the goal that she has set for herself in life, I am going to find a man and I am going to have babies. Well, she has done that. I don't know how we can prevent subsequent pregnancies when that is her goal. So one of our areas of concern is really helping them to believe in additional goals, believe that they can do something besides have babies, and sometimes dealing with very destructive relationships.

There is a program component to develop skills in family living. We go through and do intensive home visiting. Our home visitors are in once a week, minimum, and our kids all have support groups, parent education classes, and support groups. One of the things I am pretty adamant about is that you do both the home visit and the groups. This reduces isolation and deals with peer pressure.

What we have learned with a lot of teenagers is that their basic skills for daily living are so impaired, their decision making is so poor, that they are in constant crisis. One of the reasons it is hard to address any of the various needs that people identify in their lives is if they are in constant crisis. I will give you a quick example. One of our clients had rented a house from a man, but he stopped paying Laidlaw. In San Diego you have to pay Laidlaw for garbage pickup. So he told her to just put it in the garage. So for six months she is living in the house with this stuff collecting in the garage. And putting aside all of whatever our disgusted feelings are about that, the man also wasn't paying his mortgage. So the bank comes along and says to her, you are out of here. We just took the house back. You have no place to live.

So now she is in crisis. Our home visitor is working with her, let's find you a place, let's problem solve, let's do what we need to do. And she calls up and she has an answer. Her first response was she was going to rent another place from the same man! Fortunately she had a good relationship and the home visitor was able to work with her and convince her otherwise. Now this is standard. This guy was going to take care of her in her world view.

We are really trying in our Healthy Families project to identify what are the key components to what I'm calling family support programs. That is because I think to reduce subsequent pregnancies and move towards positive outcomes for teenagers, you have to do what I call family support. You need first to identify who your population is. I believe for truly impaired and dysfunctional families, they need continuous support over a period of time. One of the issues that I keep hearing is that there are all these great programs, and then at the interface the kids and the families fall through the cracks because they don't have the skills to make that jump, even if it is one little step. They need help doing it.

I'm a firm believer in home visitation plus a support group, and part of our research and what we are going to be asking is whether in fact home visiting alone or home visiting with this group component is really the key. The power of these groups is pretty amazing. It is almost shocking to see the difference between the beginning and the end of the group. We also spend a lot of time removing barriers. Some of those barriers are real simple. The girl doesn't know how to use public transportation. They are afraid. They don't know how to ask for directions. The way that they go about seeking information -- remember that no one has ever taught them -- is really problematic. So they get partial information and they respond to partial information and then it becomes a barrier. So we really work with them to eliminate barriers to getting what they and their babies need. And then we do case management coordination through a pretty comprehensive team and supervisory process.

Our internal team is really very highly focused on doing ongoing assessment, ongoing case management, and we really work very heavily with counter transference issues. Working with these kids it is very easy for our home visitor to get over involved in their clients' situations. We are constantly redirecting our home visitors and pulling them out of enmeshed situations with these families.

The case management does involve them going to AFDC and going to their schools. We go and we sit down with their school counselors and do whatever it takes for that kid.

Adolescent Family Life Program (AFLP), State Department of Health Services, Sharlyn Hansen

Ms. Sharlyn Hansen is with the Adolescent Family Life Program in the Department of Health Services. She will discuss AFLP and some research recently conducted on that program concerning the program's performance in reducing repeat pregnancies among the teenagers it serves. She will also discuss the major expansion of AFLP resulting from enactment of the Cal-Learn program. Time allowing, Sharlyn will also discuss research conducted concerning the incidence of sexual abuse and exploitation among AFLP clients and their implications relative to teenage pregnancy.

I really appreciate this opportunity to come and talk with you and participate in these discussions. It validates the common themes that we've been hearing for four or five years from our programs. It is also heartening to hear the knowledge that comes directly from adolescent mothers and that is going to be so powerful for us as we do develop programs that are more integrating and more comprehensive in dealing with teenage pregnancy and repeat pregnancies.

I would like to talk quickly about AFLP, a little bit about the providers and the clients that currently make up AFLP, and then focus on repeat pregnancy strategies as they come from our providers and some pearls that people faxed me over the last week that they wanted to make sure were heard.

The Maternal Child Health Branch of the Department of Health Services contracts currently with 36 different entities, about half of them are public health departments, most of the others are community based organizations, most of them family service oriented, two school districts, and three hospitals. They are in 32 counties. Originally AFLPs were competitively awarded and one of the major criteria for AFLP was a very high teenage birth rate in the county. We welcome now with delight and anticipation the rest of the counties through Cal-Learn who will be implementing, mostly in welfare departments, case management according to our standards and scope of services. We have worked closely with Nancy Remley and her staff over the last couple of years on Cal-LEARN and learning a lot from each other in terms of approaches and philosophies and how to get the job done.

AFLP program standards represent the systematic steps of case management. What is important about AFLP case management is it is not an institution based system of case management. It goes where clients are. You've heard about the diversity of the agencies that mount this effort.

Also, you must have a network. I've come to think now that it is probably the most important aspect of some of our successes. That is a bi-level network that exists within AFLP agencies. There is the client level network where every case manager over time builds up their connections, where they go for certain things, how to work with clients in particular neighborhoods or with particular cultural diversities. In doing that successfully themselves over time, some of them call it their Rolodex interventions, they also demonstrate how clients

make connections in neighborhoods, how they start to link up with people and services. As you heard, they take people there, they demonstrate how you can call and make appointments, the very practical things. Very often they will say some of the best case management work is done in the automobile to and from appointments.

Then there is the community level network which is a mandated requirement of any AFLP or AFLP-like case management agency, with increasingly more formalized letters of agreement about the reciprocal responsibilities of the AFLP and the agency with whom they have an agreement, about what will happen to the client. I think about how important these community organization and linkages are. It has gotten to be very popular to develop coalitions of various kinds, based on a particular risk group or whatever. I would make the plea currently that if we are talking about adolescent pregnancy prevention, positive parenting, repeat pregnancy prevention, whatever, that we build on what is there now. These are people that are very savvy who identify different providers of various types within the community. They must meet together at least quarterly. Many of them now have joined other kinds of groups. They aren't necessarily a freestanding AFLP network, they may be on the Maternal Child Adolescent Health Board in the county, they may be various perinatal boards, various kinds of organizations. But AFLP and teenage pregnancy issues are always on the agenda, and this is a very powerful group.

Out of those networks often come some of the most creative interventions that have come to be over time. Yolo County comes to mind. They have developed kind of a mentoring, sister/friend project, which takes school board members, county supervisor board members, female role models who demonstrate career models, to provide real actual support. An added benefit is that they become incredibly supportive constituents for program expansion because they know firsthand through interactive working with clients.

We've been externally evaluated by UCSF in the beginning and now internally there is a recent report. Mostly, we have identified clients when they are pregnant. About 62 to 70 percent of them come in for their first pregnancies, and we always think that is a very good opportunity to begin intervention. The race and ethnicity of our clients is fairly similar to California live birth rates of 1991, for whites, non-Hispanics, Asian or other categories. We have somewhat fewer Hispanic clients at the moment, although that is increasing. We have a greater number of African American clients.

In terms of preventing low birth weight, we have been very successful in improving very low birth weight. Our rate is about .6 percent versus 1.4 percent for California. We are marching toward a Healthy People 2000 goal of 1 percent. This, I think, is particularly important, since we are working with this very high risk group, including young teens less than 15 years old, and we know that is a much greater risk group, and with African Americans.

Our low birth rate numbers are not as impressive. 7.1 versus 7.4 for California. And we are watching with some dismay a creeping upward of low birth-weight births. It may be that we haven't particularly appreciated the significance of just physical immaturity in our young women. I just recently saw the New England Journal article about these issues. But I think it

is also as our programs have been telling us in the last four or five years, we are working with an increasingly higher risk population.

In terms of school, we have always been proud of our outcomes with that. For clients that are still in school about 75 percent stay in school. That is in contrast to most other parts of the country where there is an 8 percent dropout rate among adolescent parents. Of those clients who come in having already dropped out, we get almost 40 percent of them back.

Repeat pregnancy rates. We don't have the luxury of following up on people who drop out of AFLP, so we have a very difficult time in talking about repeat pregnancy rates. Among clients who have been AFLP clients for three years, there is 42.6 percent, compared to a similar California cohort of three years which is 46.4 percent.

We were able to do more in-depth assessments last year on a number of variables related to adolescent pregnancies. We were able to work directly with David Fine and Debra Boyer in Seattle, who suggest there is a strong association between sexual abuse and teenage pregnancy rates and repeat pregnancy rates. In terms of coercion and exploitation, you've heard many presenters over this series of roundtables comment on this issue. Almost 60 percent of AFLP clients had begun sexual relationships at 14 or younger. Also 90 percent of the clients actually had their first pregnancy as a result of a desired sexual experience. So these are by choice. However:

- 40 percent reported unwanted sexual contact.
- 18 percent reported attempted rape.
- 22 percent actually had been raped.
- 16 percent of those had threatened by physical force.
- 15 percent said actual force was used.
- 13.2 percent felt that they couldn't say no because of the age of the person or the type of relationship they had with them.

Physical abuse was incredibly significant as well in this. Sixty-five percent answered yes to one of nine items related to physical abuse. Sixty percent had been spanked by adults. Of this group 11 percent had actually been removed from their homes, so there was obvious significant physical abuse issues.

In terms of violence they lived with:

- almost a third of them knew someone who regularly carried a gun or a knife.
- 30 percent witnessed injury because of weapons.
- 32 percent regularly hear gunshots within their neighborhood.
- 16 percent have seen someone killed.
- 17 percent are involved in gang activities.

So we are talking here about significant relationship disorders. And those are the points that AFLP program staff want me to stress. We are talking about relationships, we are talking

about intergenerational transmission of attachment disorders. We have people who've never experience positive parenting, don't really know what it is like to do that or receive it themselves.

So prevention is key. The AFLP programs really would like to see the emphasis on family based intervention, on much smaller caseloads, on frequent contact, continuous contact, consistency of home visitor or case manager over time. There are concerns now in bringing up Cal-Learn, about significant breaks in AFDC for agency recipients, which means they are going to lose case management, that trusting relationship, the very heart of the successes I think come out of AFLP. And I think that many Cal-Learn clients coming in now are older, so their exposure to an opportunity to build a relationship and to access the services is going to be difficult. Having a person work with a family or a client over time is critical because you can take into consideration the particular issues of that person and that family's life. You can work with them on problem solving. You can set the priorities for what is important at that moment and work on it. School may be very important, but if you have a preterm incident in the hospital or you have other things going on with this youth, you have to balance, you have to make sense of what is possible. And in doing that, you then help people understand how to manage chaos. It is working through, one by one, individualizing what that family or that person needs to make it work.

The other plea from AFLP programs is for a better response to abused adolescents from local agencies and improvement in preventive services, mental health and sexual abuse treatment, and intervention. Also, because of the multiplicity of the issues that come up, you need to have professional or well-trained individuals working with these teenagers and families. This also applies to the other programs that support these teenagers, they too are doing very difficult work. Workers' own personal and difficult issues around relationships from their early life will surface, and this just is very, very difficult work. So it is important that we prepare and support the staff who work with these families.

Local AFLP programs also note that it is not just about building skills. It is not about contraception. The longer the teens are in the program, the more successful they will be in overcoming their problems.

We also find there is a relatively high percent, 28.5 percent, of unmet need for long-term clients in things like family planning services. That isn't just about communities. I think it is about the degree to which the teenage is comfortable using clinic services. We hear often they don't particularly like going to a large clinic where they get lost or which isn't particularly adolescent focused. The other thing is we are talking about preadolescence, adolescents don't drive. So if they are beginning unwanted sexual contact at 10 or 11 or 12 years old, we need to think about access, possibly bringing these services to the client. I sometimes wish we hadn't lost public health nursing and district nursing in community intervention, because this is a need these nurses could well address.

California Education Programs for Pregnant and Parenting Teens, Ronda Simpson-Brown

Ms Ronda Simpson Brown is a Consultant with the School Interventions and Education Options Program in the California Department of Education. Ms. Simpson Brown will briefly describe their programs for pregnant and parenting teenagers and the role of these programs in reducing repeat teenage pregnancies. Ms. Simpson will also outline some important research regarding the implications of school performance in teenage pregnancy.

First of all, within the Department of Education there is more than one program and more than one way to serve the educational needs of pregnant and parenting students. I want to share a couple of things with you. First of all the Department of Education, through the State Board of Education, has a policy on pregnant and parenting students. (See handout following Ms. Simpson-Brown's presentation). This was a character building experience getting this adopted. Things that we felt were very straightforward and noncontroversial. We found that not to be the case within our diverse society of many different values, and that all views need to be heard, and, as best as possible, represented.

With regards to abstinence, we did finally come to an agreement. Traditional values and other conservative groups really and firmly promote secondary virginity. It was important for them that abstinence be reflected in a policy related to pregnant and parenting students. Secondary virginity is the philosophy that, even though you have been sexually active once, you can no longer be sexually active. I think as policymakers and implementers of the programs we need to be aware of the philosophical diversity in our society. It is linked in here with the family life and sex education guidelines which does promote abstinence. Our Board has adopted this policy, and this guides us in what we do.

Academic achievement is one of the ways we can help young people avoid challenges and consequences of teenage pregnancies. State statistics do show that those with low basic skills are at higher risk of becoming pregnant. Also, if we can improve their academic achievement, it gives them a sense of a positive future, and it points out there is something more to life than just having children. Fathering children should not be seen as a right of passage.

There are a couple of things I just want to mention and bring to your attention that I don't think we've really discussed. We have talked about cultural diversity. Statistics are basically broken into white, African American, and Hispanic. I was privileged to work in a pregnant minor program for eight years, and some of the things that came out of my experience with those programs were the existence of other cultures and their beliefs about childbearing. For example, in the Hmong population, we are seeing an increase of Southeast Asian refugees, young women, 13 years old, having babies. You can go to Sacramento City School Program and read stories that just tear your heart out about how they are 13 and their whole life has changed, but this is the cultural expectation.

In Sutter County, in Yuba City there is a large Sikh population. A couple of years ago a 17 year old Sikh teenager had her fifth child. Why? She finally had a boy. She was so excited,

she didn't have to get pregnant anymore. I think we need to understand these cultural differences when we are looking at the data.

Another issue that I want to bring up is the issue of special education. The limited research in this area of teenage sexuality and childbearing shows that young people who are in special education programs are sexually active one year before their non-special education counterparts, and they give birth one year earlier. You will find very little that is available to address this population. There is a program in Chicago that is called Arts of Living Institution, and they have developed a program that is addressing this. They are finding that the same strategies that work with the very young teenage parents and pregnant teens are working with this population. But I think in California this is something that we really haven't addressed as much as we should.

Another thing that came out when I was working in the program is that some of the young women had not completely dealt with the issue of loss. In trying to think back to those days, I was trying to think of some of the reasons and specific incidences. I know one young woman had a baby, a girl, and the baby died of SIDS. Within six months, she was pregnant again. In two other cases, the babies were relinquished for adoption, but the teenage mothers had not really conceptualized the whole process, either because their parents gave them no other option or they just didn't deal with it. Once those two young women had relinquished their babies for adoption, within the year they were pregnant again. In another incident, a pregnant teenage miscarried and another had a child who died in an auto accident. Both of them were pregnant within a year. We need to be aware of and sensitive to these kinds of issues. Data is important and I really appreciate all we have been given, but there are faces to these young women and these young men.

When I was in the program, we had the daughter of a California State Senator, another girl that was from a very conservative minister, and others that had more colorful lives, one who was pregnant was a carnival junkie or groupie. She was impregnated by the knife thrower. Her biggest thrill was that she was going with him, and they were going to stop so she could give birth in a hospital. These are real live people who have real live stories. I encourage all of you to go and visit the program, to actually talk to these young people.

In education there is a federal law called Title 9 that states that you cannot discriminate against a student because of her pregnant or parenting status. That is the law, but in reality we know that it is not always the case. Sometimes adults think of themselves as some sort of surrogate parents. We are going to make this decision for the teenage. We are going to help them. She is pregnant so she should go and be here. That is not how it should be. We work very hard at the Department to ensure that these women do make decisions and we want to promote that.

The chart (see handout following Ms. Simpson-Brown's presentation) shows different decision options for the education of the pregnant or parenting teenage. When you have the pregnant or parenting student, first of all, are they in school or out of school? Compulsory education is until the age of 18. However, we know that not all of them that are under 18 in

California are in school. Some of them are out of school for various reasons. But assuming that they make the choice to be enrolled in school, the next choice is, is it a private school or is it a public school? Moving into public school, which we at the Department work primarily with, the next decision is comprehensive school, alternative education, or adult education.

The comprehensive school is like a traditional high school. If the alternative education option is selected, there are several other options. There are also programs that we will talk about in a minute that pregnant and parenting teens can access in any of these different kinds of educational delivery systems. Within the alternative education option, they may choose a continuation school. A continuation school is a smaller school, one in which the class size is smaller, and they are required to go 15 hours a week. This may be an option, if they are having difficulty with child care transportation. Some continuation schools may have a program that serves or targets pregnant and parenting students. An example of alternative education would be where the whole education is through independent study. They can also be in the comprehensive school and get independent study. Comprehensive school is classroom seat time. So they go five days a week and usually six hours a day.

There are county based Pregnant Minor Programs which has its own ADA, its own rules and regulations. Fourteen counties in California have this program. It was established under Special Education in 1965. At that time there was a consultant in the Department who was the grandmother of the Pregnant Minor Program. Up until that time we had no special school program for these young people. It was a time when they may disappear and go visit their aunt and come back the next year, etc., etc. But being in Special Education, this department consultant was able to get this program in place by defining these teens as being temporarily physically handicapped. Although it was sunsetted out of Special Education (this was before Title 9 in 1972), it was an opportunity for schools to begin serving these young people. At that time there were school programs, district as well as county offices, that had the program. But now, because of legislation, only county offices run Pregnant Minor Programs.

Another option is the ROCP, which is regional occupational program. There is a law, probably a little known law, that if a student is 15 and if the principal of their school, whether it is comprehensive or continuation, feels the student is going to drop out, it is possible to enroll them in ROCP. In Sacramento that is run through the county, but they do work with the local districts. I don't think very many students use that option.

The community school is another option. The community schools and the court schools are run by the County Office of Education. Community schools are those that are kind of halfway between regular school and court schools. These are schools that, for example, take students who were expelled from regular schools because they brought a gun or other kind of a weapon to school. Many of them do serve students who are pregnant or parenting. You may also have fathers in these schools.

A third option in the number is adult education. In California in 1986 Senator Watson authored a bill that said if a student was pregnant or parenting, they may enroll in Adult Education with adult status, regardless of their age. There are probably 35 of these programs,

which are run through the adult education delivery system. These students can concurrently enroll in K-12 education and Adult Education. If they are concurrently enrolled, and there is a limit on the number of students that can do that, then they go to school part-time in the K-12 system, and they go part-time in Adult Education. Letting them have adult status provides a greater opportunity for them to be in school, and they may graduate and get an Adult Education credential, or they may be there for a while and then return to their other school.

The goal, regardless of what option they pick, is that they will get a diploma, get their GED, or they will pass the California High School Proficiency Exam.

Working with Cal-Learn has been a very interesting experience between the three departments (California Department of Education, State Department of Health Services, and State Department of Social Services.) We each came with our own terminology and definitions and it has been a big learning process. I think I've learned more about welfare than I ever thought I would need to. With Cal-Learn, we want parenting teens to move into these educational options in hopes that they then will transition into other kinds of postsecondary educational opportunities.

Let me just mention that we do have some programs that serve pregnant and parenting students. One of them is called PALS, Pregnant and Lactating Students, in which they get meal supplements if they are pregnant or lactating. There is another program called Safe in School, it was initiated in 1985 in the Child Development Division and provides child care either on the site or nearby. Some provide transportation and serve those that are in the seventh to the twelfth grade and serve fathers. Unfortunately, we are limited and lack dedicated staff for both of these programs.

The total students enrolled in the Pregnant Minor Program in 1993 was 3,351; 156, or 5 percent, had a repeat pregnancy. This strengthens the idea that we need to be sure that the teens have the services that they need, that they are getting an education, and there has been research that shows that an academic program will move them out of the welfare cycle.

Additionally, we have Healthy Start, although not targeted to this population, is a program in which the district can choose to serve this population. The Healthy Kids unit had a project contracted with the Sacramento County Office of Education, called Healthy Generation Healthy Learners, in which they developed wonderful materials to use by the teachers of the students having to do with substance abuse and pregnancy. We also have a vocational educational program called Gender Equity Teen Parents, in which competitively selected local districts in which provide employment, training, and job preparation for these young people.

Office of Family Planning, State Department of Health Services, Jane Boggess, Ph.D.

Dr. Jane Boggess is the Chief of the Office of Family Planning in the Department of Health Services. She will briefly discuss their current and planned work to prevent repeat teenage pregnancies.

The following are roughly the points of intervention in terms of adolescence in California, Office of Family Planning (OFP), Clinical Services. On an annual basis, we provide about a million clinical visits a year. Approximately a quarter of our client population are teenagers, and many adults were pregnant as teens. Clinic Outreach is another OFP program component where we have specific contracts in a number of counties to connect high risk adolescents to these services. Chemical Dependency Projects, we have about six of these, deal with the drug use issues. Teen Smart is another clinical intervention. The Teen Counseling Program is a program that has a lot to offer in terms of repeat pregnancy. We are right now providing about 44,000 clinical visits a year. In Teen Smart we are providing enhanced counseling, enhanced assessment and intervention skills. ENABL is a program that is for pregnant adolescents 12 to 14 years old. Through our Information and Education Programs, we have about 90 contract agencies with the State that provide a variety of services.

Probably more interesting is the direction that the OFP is going in terms of providing services to the teens in preventing repeat pregnancies. Last night I was thinking about this session today and the areas that the Office of Family Planning is moving into in terms of addressing preventing repeat pregnancies. More focused clinical services is a big issue for the Office of Family Planning. The Teen Smart program has something that we are trying to use to address the repeat pregnancies. Overall, one of the things that is tremendously important for our office and for the direction of the Office of Family Planning is to really include the particulars, it does collaboration with programs, whether it is the California Youth Authority, whether it is the California Department of Education, or the State Department of Social Services.

Dr. Wagner spoke about the difficulty of finding the silver bullet for preventing teenage repeat pregnancy in California and around the country. It is a really tough job. There aren't interventions that we can all agree address the problems; there isn't the silver bullet. And I think that one of the reasons is that we have very categorical funding in California. We don't have a comprehensive collaborative approach to the problem. Better linkages would provide an opportunity for us to start to get a handle on this problem.

Another issue that I think is tremendously important in California is the issue of cultural diversity. This was brought up by Ronda Simpson-Brown earlier. If you look at the issue of teenage pregnancy and repeat pregnancy in California, I think it really needs to be put in the broader context of the cultural diversity in the state. The whole issue of cultural norms, how they affect teenage pregnancy, early child bearing, the issue of large family norms for some populations. One of the things that the Office of Family Planning is doing in terms of trying to address this issue is working with our department's Office of Local Health and Office of Women's Health to look at these populations and try to better understand how cultural issues influence these factors. The intervention that we all need to come up with doesn't have to be

targeted specifically to one population group. It is not a narrow issue of repeat pregnancy, of early teenage pregnancy. I think with a better definition of the problem in terms of understanding the population, we are going to be a lot better off.

Dependency counseling. The Office of Family Planning, probably in terms of repeat pregnancy, in the types of counseling services that we provide, are really the biggest venue for addressing the problem of repeat pregnancy. On an annual basis, we must see about a hundred thousand clients in the counseling services that we provide. Specifically regarding dependency counseling, one of the protocols that are implemented over the state is that the client comes and is really sort of self-reporting. Was the pregnancy planned? The answer is either yes or no. I think that assessments of these problems by the clinics are better clarifying the problems. In terms of understanding what brought that individual into the clinic, and in trying to determine whether the pregnancy was planned or unplanned, I believe about 80 percent of the kids would fall into a very gray area. It is neither planned nor unplanned.

I think more focused services, more focused counseling services on issues of teenage pregnancy would be a very important thing to deal with. And another area that is tremendously important is the issue of wellness services. Whether it is the Office of Family Planning, or California Department of Education, or the State Department of Social Services, it really is an issue of linking up and building on what does work. I would hope over the next several years that the Office of Planning, especially with an eye toward the limited funding for teenage pregnancy prevention services, that there would be a very concerted effort to link up and make sure that whatever we are doing is done in a more comprehensive way -- whether it is education programs, AFLP, or Cal-Learn -- to really attempt to develop a little comprehensive relationship.

The Home Visitation Model and Planning Efforts to Reduce Repeat Teenage Pregnancy, Children and Family Services, State Department of Social Services, Marjorie Kelly

Marjorie Kelly is the Deputy Director for Children and Family Services in the State Department of Social Services. She will discuss current Department of Social Services activities and planning to reduce repeat teenage pregnancy and, in particular, the home visitation model.

The kinds of things that I'd like to focus on here are the multiplicity of issues to be faced in a public policy arena when we look at the problems and issues related to teenage pregnancy, how those relate to the kind of work that I do in my division at the State Department of Social Services, and the connections of support we put in place between all the state departments that touch on this problem.

There is no simple solution, but I think that being a person who "sees the glass is half full," what I would like to say is, I think we know an awful lot more today than we used to. That is clear. And we have many program models that are showing great promise and great potential. I think it is one thing to say this is a terribly complex problem. And sometimes that is depressing and overwhelming. I think it is also important to say we have better research, better data, better knowledge and a better understanding of the dynamics of teenage pregnancy and single parenthood today than we ever did before. We have more research going on today than we ever did before. And we have more promising program development today than we ever did before. So while we have an enormous amount of work to do, I would suggest to you that we have come a very long way in what we need to be about at this point in time. There are a couple of things specifically related to outlining and focusing on those things within our own agencies that we know impact on the issues and problems, and then, secondly, to put this together into a multidisciplinary effort. And I will close my remarks in a few minutes with some ideas about what needs to be part of that effort.

The division that I lead in the Department of Social Services is the division that has to do with child abuse and neglect, foster care, adoptions and child abuse prevention. What you have heard in previous seminars and what you have heard today, I think, is very consistent. A great deal of teenage pregnancy is caught up in the issues of hopelessness and that those issues of hopelessness frequently, if not almost always, stem from a very difficult family background, and, unfortunately, frequently from a background of sexual exploitation or overt sexual abuse of the young mom.

This is particularly one of the reasons why we will need to talk about the multiplicity of efforts. It is a circular problem and it affects simultaneously men, teens, moms, and babies. This is not an issue where you can say that teenage pregnancy is a problem, here is a teenage, here is a solution. Because that teenage mom has a mom who is probably depressed and has probably had a background of violence and sexual exploitation. She is now the grandmother, the mother to a teenage who is the mother to a baby. The teenage who came through the same cycle in a home where she was not protected. While we have many single parent homes

that do very well and are very strong, one of the issues that we need to confront is that children in single parent homes are more vulnerable. They are more vulnerable to the people passing through the homes, they are more vulnerable to predators, and they frequently are in homes where the mom in the household has experienced the types of problems and issues that we are talking about teens experiencing. You don't just have multigenerational anxiety, you have multigenerational depression, multigenerational abuse and multigenerational forms of hopelessness.

Let me just say a couple of words about sexual abuse that I think are critical to understanding the scope and dynamics of what we are dealing with. Nationally, and the figures in California, track pretty well with the national statistics, around 15 percent of the child abuse and neglect intake or findings are related to sexual abuse. This is added to another 25 to 30 percent physical abuse. Maybe about 15 percent nationwide of our child abuse intake in Child Welfare Services is sexual abuse. But what we find is when we bring kids into foster care, another 35 percent show up later as having been sexually abused. So when we look at our child abuse and neglect caseloads, look at two figures. One is the figure initially reported, which is the immediate finding. The second is we are finding that the immediate finding is only a fraction of the sexual abuse we are encountering.

I just came from a meeting in Washington, D.C., with other child abuse directors around the country, and there was enormous consensus from those programs that probably half of the caseloads we are dealing today in child abuse and neglect include sexual abuse, regardless of how the case was initially reported or founded.

The second thing I would like to just say about sexual abuse, and this is a quote from somebody who worked in the field for a very long time, "Unless 50 percent of your caseload is boys, you are missing them." So when we deal with sexual abuse as an issue, and when we are dealing with the subject matter that we are talking about today, teenage moms, what we need to keep in mind is that sexual abuse is a phenomena that generally equally affects boys and girls. It is more likely to be discovered with girls than it is with boys, for some reason, likely social reasons, that I won't go into today. But I think that it is important that we start to think about that and that we include it in our thinking. Because when we are targeting programs, whether they are health care programs, welfare programs, child abuse programs, we need to keep in mind that the population is not just the teenage mom, but it is also the young men who are growing up frequently with very maladapted ideas about their own sexual identity, about their own role in a family and with women, and what kind of a role they play in terms of being exploiters or protectors, perpetrators or protectors of their children. That is a particular issue that we haven't paid a lot of attention to, not to the degree that we should. Maybe in a different forum explore that a little more at some future time. I think our friends from the Youth Authority and from County Probation would probably provide some support as to the idea that there is a lot more sexually abused boys out there than anybody is willing to admit or think about or that certainly we have been able to count.

In child abuse, obviously, child abuse prevention is a priority for me. If I have to pick my number one priority in the job that I do, it is indeed child abuse prevention. I am far more

interested in finding ways to do voluntary, nonadversarial, family strength and support- based work than I am in cleaning up after terrible things have happened to children and have happened to families. I think the efforts of our number one priority in child abuse and programs that we provide is to make sure that kids are safe. That includes an intervention component. We must simultaneous and constantly work vigilantly toward prevention because it is through the kinds of situations that we see that prevention becomes more and more important.

Clearly home visitation is one of the primary programs that I'm interested in. We have also been working on family resource centers. These are two kinds of major child abuse prevention efforts that are going on in the country. My favorite is home visitation. Our Office of Child Abuse Prevention has funded a number of home visitation projects. Recently, we have cooperated with Stuart Foundation and California Wellness Foundation to fund the San Diego Healthy Families Research Project. It is a five-year control study. It is funded, by the way, with the Federal Family Preservation and Support moneys. Although OCAP is administering the contract, OCAP is not actually funding the project. For those of you in policy positions, I thought you would like to know where a little bit of the Federal Family Preservation and Support money is headed, and we are very proud that we were able to do this with that money.

I would like to emphasize something that Terry Carrilio mentioned earlier. We are looking at a number of issues, including testing as part of this project subsequent fertility and employment. We were piqued by the findings from the Elmira, New York, project in which they found that women in the program showed an 82 percent increase in the number of months they were employed, 43 percent fewer subsequent pregnancies, and postponed the birth of a second child on average of 12 months longer than the control groups. The women in the program are not necessarily teens. Without getting into a debate of which numbers on which persons on which level are served in the Elmira Project, I think that the point I would like to make today is that there is some very promising information on the impact of home visitation on any number of things. Our focus, of course, is child abuse and neglect prevention, but in this case it was also focused on subsequent fertility and on employment. So those are two things we are looking at.

We have funded a number of projects through OCAP, and we've got projects in the first and second year stages of start up and operation. In addition to the research project in San Diego, many community based agencies have started projects on their own, many health related agencies have started projects on their own and some county Departments of Social Services are now thinking about it or planning home visitation as the family preservation and support effort. With all of the things going on, I frequently talk extensively with the foundations that are working in this area, with the Stuart Foundations and The California Wellness Foundation, and there are some who are interested in co-sponsoring a conference on health education. We have probably reached a point in time where we need to actually hold a conference to look at a lot of the home visitation work that is being done around the country as well as in California, looking at the projects that are going on, and the research that is going on. There is a major research effort going on in Hawaii, out of Johns Hopkins University, and we need

to bring those folks together and start to look at that. I think we should get together and think about how we can bring some more attention and time to this effort.

What I'd like to say in closing, is simply that I think a strategy around teenage pregnancy and some of the issues that we are trying to address will probably involve at least seven different components. The ones I've talked about are child abuse and neglect prevention. We are interested in home visiting and getting kids off to a healthy start that includes an opportunity to have a better bond with the parents, besides all the other things we talked about such as health care, and a child's need to have a primary and secondary parent. That instinct to protect builds a good healthy bond and attachment between a child and parent.

Secondly, we do indeed agree that we need better efforts to identify, treat and then finally prevent sexual abuse. We have many children who are very vulnerable, children who are being sexually abused. We need to constantly be looking at our statistics, our circumstances, and why we are or are not picking up kids, particularly teenagers perhaps or early adolescents, better or more than we are.

Thirdly, I think we need to continue the kinds of teenage programs and expand the kinds of teenage programs that we've talked about, educational school based programs, TAPP programs, contraception and so forth. Counseling support, all the kinds of things that we can target towards teenagers who are sexually active or who are vulnerable.

Fourthly, I would like to propose that this effort includes law enforcement. I don't think we can talk about this without the Department of Justice and local law enforcement. You've heard it: adult males, young girls. I think that law enforcement is going to be a critical component of bringing attention to the issue of adult males impregnating young girls.

And connected with that issue I think is squarely facing our social attitudes and our social acceptance of sexual contact between young girls and older men. I think we have been ambivalent on that point and I think we should talk about it. I think it is about time we start talking about whether a 13 or 14 or 15 year old girl particularly in an abused girl, is indeed able or actually does give consent for a sexual relationship with a 25, 28, 35 year old man. So I would like to put that on the table. We haven't talked a lot about it, but frankly, it is a factor in how good a job we are doing in identifying sexual abuse and treating sexual abuse among teenagers, because we have been ambivalent about whether or not it is abuse. So we are going to have to squarely face that.

Sixthly, I think welfare reform is critical, welfare reform in the context of education, training, work expectations and employment opportunities. We are talking about people who have been dependent for generations, and I think frequently are recipients of public aid. Clearly, welfare reform is going to be a part of the effort that not only creates greater expectations but also creates the opportunity to engage in educational and work related programs that the kinds of families we are working with may not otherwise be exposed to.

Finally, the whole area of physical and mental health and family planning and contraceptive resources needs to be complete, needs to be accessible, and needs to be community-based and readily available to the moms and teens in the neighborhood.

Cal-LEARN Program, State Department of Social Services, Nancy Remley

Ms. Nancy Remley is the Manager of the new Cal-Learn program, the program which is to assist teenage mothers on AFDC to stay in school and graduate. She will discuss very briefly how that program operates and its relationship to AFLP.

Many of you are very familiar with the Cal-Learn Program and probably know more about welfare reform than you probably ever want to, but some of you are new. Like so many of you in the room, I am used to working in contradictory terms, or an oxymoron. I can't think of anything more contradictory than the term: teenage parent. I was schooled in the Erickson theory of behavior which identifies adolescence as a time wherein you search for identity, you develop the social morals and sense of responsibility, relationships with peers, and skills, both vocational and educational in order to become an independent adult. That is what adolescence is to me. When you overlay that with the roles and responsibilities of parenthood I think that a teenage parent must experience, at a minimum, a daunting task, if not outright impossible. I don't think it should surprise any of us that 60 percent of our existing AFDC caseloads are made up of women who have their first baby when they were in their teens.

The Cal-Learn Program was designed as a form of welfare reform. Envisioned five and a half years ago, it was designed to target AFDC teenagers, pregnant and parenting, and to assist them to attain a high school diploma. Through its evolution over the last several years, the Cal-Learn Program has developed into a comprehensive service system that we believe gives California the opportunity not simply to address the educational needs of teens to attain self-sufficiency, but to also address the myriad of life skills, parenting skills and responsible life choices.

I will briefly go through how I believe the program does that, and the decision we look for at the end. First we use fiscal incentives and disincentives, based on school report card performance, to induce teens to return to and to stay in school. Not only do we know that a high school diploma is a minimum entry requirement to most employment, but it also provides the tools for success and self-confidence that these teens are so sorely lacking in.

Second, and incredibly significant, is the role of case management. Case management is based on the Adolescent Family Life Program model, where the case manager acts as an advocate and helps the teenage parent by providing a role model to the teenager. We have heard there are so few role models for not simply parenting, but also for responsible adult behavior. In addition, the case manager's responsibility is to identify and address service needs, not just educational but also health services, parenting skills, substance abuse, and to work with the local agencies to locate those services for the teenagers.

Finally, Cal-Learn reimburses necessary supportive services, including child care. It is becoming apparent to us as more and more important the need for child care. We are looking at how to develop and expand child care resources in order for the teenager to access school. We believe this goes far beyond the welfare concept of providing a place to leave an infant while the welfare recipient attends an activity necessary for independence. What we are

beginning to look at is a child care system that provides role modeling for the teenagers, that introduces the teenage parent to responsible choices for child care, that provides a wide opportunity of different child care arrangements so that the teenage parent can begin to understand and make responsibility choices as a parent for the care of her infant and also to understand the complexities of her child.

The challenge, at a minimum, is to implement this program. In conjunction with the Department of Health Services and Department of Education I have been working on this for over two years now, and I am pleased to say that, as of today, all 58 counties have now agreed to implement the program. Given the change in political climate at a local level, you might understand that this has been a bit of a challenge. Our April county statistical report that the county welfare departments provide to us indicate they have identified over 9,000 teens eligible for the program. Not all of those teens received case management, because the AFLP agencies providing case management are growing at double and triple and sometimes ten times their size. So replication of the case management model remains a substantial challenge, and we support and encourage the concept for professional workers, trained and knowledgeable workers, to continue to provide services to these teens to ensure the program's success.

Other challenges: the location of necessary services. At a minimum, we make an impact on the public school system as these teens return to schools. What about the necessary health services, not the least of which would be family planning services? What will be the impact on child care or infant care? Finally, how will we know whether or not this program is working? Unlike other programs which we have described today, I don't have statistics yet. I hope to have them within a two year period and certainly in five years. Because this is a program based on federal waivers, it will have a very comprehensive evaluation that will answer not simply, the question of success for our California clients, but what made it a success. Was it the case management intervention? Was it the fiscal incentives and disincentives? Did it require the whole concert of services or were there other areas that actually induced these teens to become successful adults? It will look at such things as repeat pregnancy and family structure and whether or not siblings were also affected by teenage pregnancies within the household. At the end of this, we should have a substantial knowledge base on what techniques and interventions will actually work with the teenage parent population.

In closing, I would like to address something that has become remarkably apparent to us as we talk about teenage pregnancy. We have 11 and 12 year olds in the programs. So we are addressing teens and preteens and we are addressing children in grade school and in junior high. And one of our most important missions will be to display the gamut of services necessary for 11 and 12 year olds, as well as our 18 year olds who are very well on their way towards independence and self-sufficiency.